HOSPITAL ABSTRACTS

A MONTHLY SURVEY OF WORLD LITERATURE

PREPARED BY THE DEPARTMENT OF HEALTH

AND SOCIAL SECURITY

VOLUME 18, NO. 12, ABSTRACTS 1736-1891. DECEMBER 1978

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Zeitschrift für die gesamte Hygiene und ihre Grenzgebiete, Rosenthalerstr. 28-31, DDR-102 Berlin, Germany.

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Masson Publishing U.S.A. Inc., 14 E 60th St., New York, N.Y. 10022, U.S.A.
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North London Polytechnic, Prince of Wales Rd., Kentish Town, London NW5 3LB.

Oxford University Press, Ely House, 37 Dover St., London W1X 4AH.
Royal College of Surgeons, Lincoln's Inn Fields, London WC2A 3PN.
Van Nostrand Reinhold, 430 Park Ave., New York, N.Y. 10022 *and* Windsor House, 46 Victoria St., London SW1.
Volunteer Centre, 29 Lower Kings Road, Berkhamsted, Herts. HP4 2AB, England.
Westview Press, 1898 Flatiron Court, Boulder, Colo. 80301, U.S.A.

HOSPITAL ABSTRACTS

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HOSPITALS IN GREAT BRITAIN

1736. LEE, M. **Private and national health services.** (Vol. XLIV, no. 578) London, Policy Studies Institute, 1978, iv, 23pp. £2.20

This broadsheet brings up to date a study on the private sector of medical care, published in 1971. It briefly deals with the political, social and economic issues particularly in terms of the possibilities and potentialities of a separate private health service. There are three sections: (i) phasing out private beds; (ii) private health services; and (iii) future prospects.

1737. CULYER, A. J. and others. **What accounts for the higher costs of teaching hospitals?** *Social and Economic Administration*, Oxford, 1978, vol. 12, no. 1, pp. 20-30.

Specific input-output concepts and statistical techniques are used to analyze the relative costs of teaching and non-teaching hospitals. The analysis highlights a number of factors not previously so readily visible to an observer of teaching hospitals: (i) there is a strong association between the National Health Service costs of teaching hospitals and their student load; and (ii) an examination of individual departments shows that there are differences in the way in which the teaching function imposes costs on departments, affecting unit costs and units per case differentially.

HOSPITALS IN OTHER COUNTRIES

See also Abstract No. 1869

1738. ADAMS, G. and BURGUN, J. A. **Hospital remains in inner city by moving to recycled factory.** *Hospitals*, Chicago, 1978, June 1, vol. 52, no. 11, pp. 61-63.

Lutheran Medical Center, Brooklyn, N.Y., has opened its new 532-bed hospital in a converted foundry—possibly the first building of its kind to be put to such use. First the five-storey, reinforced concrete building was gutted, then new boilers, an emergency power system, a radiant heating system for patient air-conditioning and heat-recovery wheels were installed. A new front entrance leads to a circulation core, serviced by eight lifts and two escalators, and to the lobby, which is one storey above street level. Six medical and surgical units occupy the top three floors. Other facilities include 10 major operating theatres, two cytology rooms, four delivery rooms, two special procedure operating theatres, 10 radiography and fluoroscopy rooms, and an extensive ambulatory care unit. Each nurse's station and the patient rooms that it serves are identified by a bold and distinctive colour scheme. Five photographs are included, but no plans.

1739. BETHUME, E. Centre public d'aide sociale de Charleroi: l'hôpital civil de Jumet. **[Public centre for social welfare, Jumet Civil Hospital, Charleroi, Belgium.]** *L'Hôpital Belge*, Bruxelles, 1978, May/June, no. 133, pp. 7-11.

This is a brief description by the architect responsible for the design of the new 476-bed general hospital at Jumet. The main block is a long thin rectangle, eight storeys high; the top five storeys are reserved for wards. Extending backwards and downward from the centre of this main block is a central three-storey block which contains the operating theatres, dialysis unit, radiology department, records, and kitchens. To the left of this block and parallel with the main block, but below it because of the sloping nature of the site, is another wing which contains two geriatric units, a rehabilitation unit, the cobalt therapy unit, the isotope unit, the laboratories, and the staff restaurant. A photograph of the exterior illustrates the problems presented by the nature of the terrain; there are also five photographs of the interior and a plan of the building.

1740. CALANDRA, R. and CARTA, G. L'ospedale di Partinico. **[The Partinico Hospital.]** *Tecnica Ospedaliera*, Milano, 1978, June, vol. 8, no. 6, pp. 40-50.

The new general hospital at Partinico, a country town some 30 kilometres from Palermo, was designed by Antonio Bonafede. The hospital, which cost nearly three thousand million lire, has 270 beds and is intended to serve an urban and rural population of 59,000. The design is conventional, with services, laboratories, out-patient clinics, operating theatres, offices, and the radiology department on the lower floors. The wards face outwards to the East and South in two blocks at right angles to each other linked by a square central tower. Four photographs and five plans are included.

PLANNING, DESIGN AND CONSTRUCTION

See also Abstract Nos. 1767, 1862

1741. BOYAR, R. L. **Flexibility planning keys cost-effective construction.** *Hospitals*, Chicago, 1978, May 1, vol. 52, no. 9, pp. 79-80, 83.

When planning capital developments, it is imperative that all those involved should recognize the importance of flexibility of design. Long-term cost savings can be realized if hospital buildings are designed with change in mind. Elements of design which limit flexibility include: building configuration; restrictions on column spacing and alternative bay sizes; minimizing shafts; reduced floor-to-floor heights; lack of provision for both horizontal and vertical expansion; and lack of necessary mechanical and electrical services. There is no simple solution, but a combination of long-span design with interstitial space, void of interior vertical elements within the building proper, might provide the universal building space amenable to almost any change that future needs might require.

1742. CARLISLE, B. **Construction manager can reduce costs, frustrations.** *Hospitals*, Chicago, 1978, May 1, vol. 52, no. 9, pp. 87-88, 90-92.

Although the construction management approach has several variations, the essence of the concept centres around the introduction of a construction manager as the owner's

agent and as manager of the entire building process. There is no prime general contractor, and each segment of construction is contracted separately with the advice of the construction manager. A principal benefit of this approach is that it lends itself to fast-track phase construction, which can often result in major time savings. The construction management approach provides three significant benefits for the owner: (i) it adds a general contractor's knowledge to the expertise of the architect; (ii) early in the design phase, it uses a system that controls staff, money and materials; and (iii) it provides overall management to break down the sequential pattern of the traditional approach, allowing design and construction to proceed simultaneously.

BUILDING: TENDERING, ETC.

1743. FEELEY, R., WALSH, D. C. and FIELDING, J. E. **Structural codes and patient safety: does strict compliance make sense?** *American Journal of Law and Medicine*, Cambridge, Mass., 1977-78, vol. 3, no. 4, pp. 447-454.

The recent trends towards enforcing the building and safety codes for health care facilities in the United States are discussed. The estimated costs (in dollars spent) of the trends with their anticipated benefits (in terms of potential years of human life saved) are compared. For each potential year of life saved, strict enforcement of the Life Safety Code of the National Fire Protection Association would cost from $12.7 to $63.5 million for hospitals and $1.1 to $2.6 million for nursing homes, the latter figure based on Massachusett's experience. These figures are constrasted with the cost of routine kidney dialysis, which is acknowledged to be an expensive technology, costing approximately $20,000 per potential year of life saved. The authors suggest that even if strict enforcement of the Code were fully effective, a portion of the financial resources expended from the national health care budget might be better spent on other activities with greater potential yield in improving the quality of life for patients in hospitals and nursing homes.

BUILDING COSTS

See Abstract No. 1742

CONSTRUCTION METHODS AND BUILDING MATERIALS

See Abstract No. 1753

HOSPITAL DESIGN

See also Abstract No. 1741

1744. TORTORICI, G. Un modulo funzionale e strutturale nella degenza ospedaliera. 1e parte. **[A functional and structural module for designing hospital accommodation. Part 1.]** *Tecnica Ospedaliera*, Milano, 1978, March, vol. 8, no. 3, pp. 25-44.

In the first of two articles the author briefly examines the reasons for the introduction of industrialized techniques into hospital construction and emphasizes the need for

careful preliminary planning to ensure that the components manufactured off-site will all link up harmoniously on-site. The dimensions of the basic modules and the structural systems (transverse or longitudinal) used in 11 German and five French hospitals are given in two tables and the plans of five French and seven German hospitals accompany the text.

1745. TORTORICI, G. Un modulo funzionale e strutturale nella degenza ospedaliera. 2e parte. **[A functional and structural module in hospital accommodation. Part 2.]** *Tecnica Ospedaliera*, Milano, 1978, April, vol. 8, no. 4, pp. 21-35.

In the second of two articles (see Abstract No. 1744) the author describes the development of the use of industrialized building techniques in hospital construction in Great Britain and attributes its success to the overall co-ordinating action of the DHSS. He explains the purposes of DHSS publications such as Hospital Building Notes, and Hospital Technical Memoranda, and outlines the content of the CUBITH and Harness hospital building programmes. In Italy the government has done little to encourage the use of industrialized techniques. The author suggests that optimum values for Italian requirements should be determined and that a methodology of building operations in which prefabrication can be used should be elaborated. He puts forward his own proposal for a structural module for hospital wards. The article includes plans of four British and four Italian hospitals.

DESIGN OF INDIVIDUAL GENERAL HOSPITALS

See Abstract Nos. 1738, 1739

EXTENSIONS AND RECONSTRUCTIONS

1746. LARSEN, O. Utbyggingen av Sentralsykehuset i Rogaland. **[Extension of Rogaland County Central Hospital.]** *Norsk Sykehustidende*, Oslo, 1978, May, vol. 51, no. 4, pp. 114-117.

The plans agreed in 1970 for the extension of Rogaland County Central Hospital involved an 108,500 m^2 building with a total of 1,115 beds, costing n.kr. 274 million in 1969. However, in 1975 the Norwegian Government recommended that out-patient services should be extended significantly whilst hospital diagnostic and therapeutic activities should be stabilized. The hospital extension committee therefore decided to modify the first stage of the extension plans and run the second and third stages into one, to be completed in 1981. The 16,000 m^2 first (western) stage, opened on 1 August 1978, has eight storeys comprising: cleaning facilities (basement); entrances, physiotherapy and bed centre (ground floor); paediatrics, out-patients and ear, nose and throat (first floor); neurophysiological laboratory, and neurological and eye out-patients' departments (2nd floor); and children's centre (3rd to 5th floors). The 2,150 m^2 boiler house is complete and is sufficient to supply the second (southern) stage and the Psychiatric Department. The South block will comprise offices (basement); acute admissions (ground floor); department of surgery (1st floor); technician's departments (2nd floor); and wards (3rd to 7th floors). The hospital currently has 829 beds in its five widely separated departments. The article is illustrated with an aerial photograph of the present buildings.

DESIGN OF SPECIAL DEPARTMENTS

See Abstract No. 1793

DESIGN OF SPECIAL HOSPITALS OR UNITS

See also Abstract Nos. 1836, 1876

1747. BEATTIE, A. **Space organization in the accident-and-emergency department: a case-study in the application of computer methods to problems of hospital department layout.** (M.A.R.U.4/74) London, Medical Architecture Research Unit, Polytechnic of North London, 1974, [101]pp. £2.00

This report summarizes and reviews work carried out under a DHSS commission with an aim 'to extend and develop the methods of computer-aided design, already initiated in a parallel study of the design of out-patient departments, to other hospital departments'. The report describes the experiments that have been conducted; demonstrates some of the results and discusses the usefulness and implications of these investigations; and draws some general conclusions concerning the feasibility of rationalization, standardization and automation of design for the accident and emergency department.

ENGINEERING SERVICES

ARTIFICIAL LIGHTING

1748. HOLLWICH, F. and DIECKHUES, B. Kann künstliche Beleuchtung das Tageslicht voll ersetzen? **[Can artificial light provide a complete substitute for daylight?]** *Krankenhaus-Umschau*, Kulmbach, 1978, June, vol. 47, no. 6, pp. 456-458, 461.

Artificial lighting which exceeds a certain strength (this differs from person to person) leads to symptoms of stress. Except for special purposes lighting at workplaces should not exceed 750 lux. In windowless rooms, or where artificial light is needed to supplement daylight, a combination of lamps of different colour should be adapted, more than has so far been the case, to the specteral light intensity distribution. In windowless rooms it is possible to incorporate artificial windows in the side walls with "combination lighting" which creates conditions similar to daylight. More attention should be paid to the biological effect of lighting on the human organism.

COMMUNICATION SYSTEMS

1749. STADTHERR, K. O. Elektronische Kommunikationssysteme im Marienhospital Gelsenkirchen. **[Electronic communication-systems in the Marien hospital, Gelsenkirchen.]** *Krankenhaus-Umschau*, Kulmbach, 1978, June, vol. 47, no. 6, pp. 462-464.

The new Marien Hospital at Gelsenkirchen is reputed to have the most modern and

most extensive electronic communications system. The integrated communications unit at each patient's bedside includes: a telephone for internal and external calls; a universal press button which gives direct access to a nurse or a doctor at any time during day or night; and earphones for listening to any of three radio programmes. An illustrated account is given of the whole communications system which also includes paging, fire alarms, an electric clock system, and television control of the hospital entrance.

TRANSPORT IN GENERAL

See Abstract No. 1875

HEATING

1750. APPLEGATE, G. **Heat recovery by air to air regeneration.** *Hospital Development*, London, 1978, May/June, vol. 6, no. 3, pp. 24-25.

This short paper outlines the installation and performance of a Heat Regenerator at the Royal National Orthopaedic Hospital, London. It operates in conjunction with the air-conditioning plant and is housed in the main plant room. Three diagrams and a photograph are included.

1751. TENART, G. Les hôpitaux et le problème de l'énergie. **[Hospitals and the energy problem.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1978, May, no. 392, pp. 78-82.

In the light of the current energy crisis the author briefly examines alternative sources of energy which may become available: solar energy, geothermal energy, heat pumps, and nuclear energy. In the meantime, the hospital can achieve energy savings in a variety of ways, for example: by maintaining its heating equipment in good order; by correct insulation; by recovery of energy from the incinerators; by replacement of conventional cookers by infra-red ovens which use very little electricity; and by careful supervision of consumption of energy for laundry, ventilation, hot water, and lighting. There is an additional note on the savings which can be achieved simply by ensuring that electric light bulbs are clean.

1752. **A total energy centre for Wellington Hospital.** *New Zealand Hospital*, Wellington, 1978, April, vol. 30, no. 3, pp. 23-24.

The complete redevelopment of the Wellington Hospital site led to the planning of a total energy centre to serve the whole hospital. Electricity will be produced by four engine generators and will be circulated round the site by a ring main system. Waste heat from the engine generator will supply: (i) the domestic hot water; and (ii) a heat source for air conditioning and space heating. The centre will also supply steam for sterilization and chilled water for the air-conditioning system. It will have a control room with a central monitoring system and is designed to change from gas to oil firing in an emergency. Limitations with regard to noise and vibration transmission are being strictly adhered to.

EQUIPMENT, FITTINGS, FURNITURE

EQUIPMENT GENERALLY

See Abstract Nos. 1750, 1860

MEDICAL EQUIPMENT

See also Abstract No. 1853

1753. Hiss, H. Einflüsse der medizintechnischen Einrichtung auf das raumschliessende System. **[The influences of medical engineering equipment on the surrounding room-system.]** *Krankenhaus-Umschau*, Kulmbach, 1978, June, vol. 47, no. 6, pp. 447-448, 453-454.

This paper is concerned with the effect of medical equipment on the design and construction of hospital floors, walls and ceilings. It is based on experience gained during the planning and construction of the building for the Faculty of Medicine, Göttingen University, for examination, treatment, research and theoretical medicine. The aspects dealt with are primarily flexibility, installation, reinforcement and radiation protection. Details are given of materials used, modules, etc., for such areas as the X-ray department, operating suite and dental clinic.

AUDIO-VISUAL EQUIPMENT

See Abstract No. 1837

ELECTRONIC EQUIPMENT

See Abstract No. 1873

STAFF GENERALLY

STAFF COMPLEMENTS

1754. Allsted, T. Bemanning etter pasientens behov? **[Staffing according to patients' needs?]** *Norsk Sykehustidende*, Oslo, 1978, June/July, vol. 51, no. 6/7, pp. 164-166.

Parliament has progressively reduced the working week from 42½ hours to 36, as a result of which the health service required the establishment of 4,000 more posts in compensation. Only 1,800 new posts have been voted, which must be interpreted as meaning that the authorities regard the health service as having been over-manned and inefficiently (non-rationally) run. Health institutions must therefore look within

themselves for rationalization measures, without these affecting the care and attention given to the individual patient. Wards must be staffed to meet the patient's requirements —physical, mental, intellectual, social and religious, and the patient must receive individual treatment. Parliament's own legislation governing staff working conditions must be observed, while staff must feel secure vis-à-vis difficult patients. Staff must visit patients at least twice a day, and be prepared to spend time at the bedside. Office and side-room responsibilities must be discharged, and the dying and their relatives given special attention. Individual patients must be studied and their need for attention assessed on the basis of a standard system, defining the number of hours' nursing each case requires, thus permitting exact staffing levels to be determined and wards to be made directly comparable. The nurse to auxiliary ratio should be 60/40, with 51 per cent of the staff on fore-noon duty, 34 per cent on evenings and 15 per cent on night duty. The article is illustrated with a hypothetical example of an ideal 75-bed acute medical ward.

CONDITIONS OF SERVICE

See Abstract No. 1760

STAFF TRAINING

See Abstract Nos. 1755-1757, 1799, 1856, 1883

STAFF WELFARE

See Abstract No. 1802

SPECIAL CLASSES OF STAFF

ADMINISTRATIVE AND CLERICAL STAFF

1755. DANMARKS FORVALTNINGSCHØJSKOLE. Betänkning vedrørende forvaltningsfaglige diplomkurser for sygehusadministrativt personale m. v. på Danmarks Forvaltningshøjskole. **[Report on the management diploma course for hospital administrative staff at the Danish Management College.]** *Tidsskrift for danske Sygehuse*, Glostrup, 1978, May, vol. 54, no. 5, pp. 81-85.

A two-year (330 hour) Part I course for hospital administrative staff commences in September 1978, comprising (i) public sector economics, (ii) community structure and (iii) local authority economic planning. Applicants must be qualified in mathematics and statistics. Part II of the course, planned for 1980, covers: (i) health policies and priorities (30 hours); (ii) trends in medical and technological development (30 hours); (iii) hospital planning (60 hours); (iv) hospital construction (30 hours); (v) hospital staff management (30 hours); and (vi) running a hospital (60 hours). The 240 hours of the Part II training are to be taught during eight, one-week courses spread over an academic year. The detailed syllabus and textbooks are quoted for the entire Part II course.

MEDICAL STAFF

1756. PICKERING, G. Sir. **Quest for excellence in medical education: a personal survey.** Oxford, Oxford University Press for the Nuffield Provincial Hospitals Trust, 1978, vii, 102pp. £4.50

As a result of the Christchurch Conference of 1961 and the Pembroke Conference of 1973, both on the subject of graduate and continuing medical education, this survey of medical education in the United Kingdom was carried out. This report is based on the author's visits to several medical schools, Royal Colleges and faculties. Aspects analyzed include: the regulation of medical education; postgraduate and continuing education; undergraduate education: examinations; the special case of London; and conclusions. Five appendices are included covering: institutions visited in the course of preparing the report; programme for the month of February for the Postgraduate Medical Institute, Stoke on Trent; report on the Southampton Medical School; extracts from the Science Masters' Association Report; and a surgery exam paper from Oxford University, June 1965. A list of 30 references is included.

1757. STROSS, J. K. and HARLAN, W. R. **The impact of mandatory continuing medical education.** *Journal of the American Medical Association*, Chicago, 1978, June 23, vol. 239, no. 25, pp. 2663-2666.

The continuing education habits and attitudes of physicians in Michigan were surveyed after a law had been implemented making continuing medical education (CME) mandatory. The results were compared with a previous survey carried out seven years before. The two surveys were not exactly comparable, but the groups were similar in age, practice locale, and specialty distribution. The CME habits and attitudes do not appear to have been altered by the new law, the amount of time spent on CME activities has not changed appreciably, and there have not been any major changes in preferences for CME activities. More than 75 per cent of physicians endorsed mandatory CME. It is not possible to state that the law has had any direct effect on improving the quality of care, but it has been instrumental in initiating educational activities in community hospitals.

NURSING STAFF

See also Abstract Nos. 1822, 1831, 1856

1758. DEWAR, H. A. **The hospital nurse after Salmon and Briggs.** *Journal of the Royal Society of Medicine*, London, 1978, June, vol. 71, no. 6, pp. 399-405.

The Salmon Committee report (1966) left the senior administrative nurses better paid than the practising nurse, but executing tasks which might well be done by non-nursing staff. Despite the excellence of most of the Briggs report (1972), problems with ward sisters and staff nurses remain. The author recommends the presence of both an older senior sister and a junior sister on the ward, the latter taking her full share in ward organization as well as getting to know the patients. Teaching could also be included in the sisters' duties. Standards of nursing have not improved since Salmon. Often the great complexity of, for example, drug therapy, leads the nurse to forget

aspects of basic care. The problems are most acute where long-term care of geriatric and mentally ill patients is involved. The Salmon report separated the teacher of nurses from the ward, but she is now returning. The author proposes several radical changes in the structure of nurse teaching.

1759. DAVIES, C. **Four events in nursing history: a new look.** *Nursing Times*, London, 1978, June 22, vol. 74, no. 25, occasional papers; pp. 65-68; June 29, vol. 74, no. 26, occasional papers; pp. 69-71.

A new interpretation is provided of four important events in British nursing history: (i) the establishment and early character of the professional association (now the Royal College of Nursing), from 1915 to 1925; (ii) the establishment of a register under the Nurse Registration Act of 1919 and the State support it involved; (iii) the pressure nurses brought to bear on the shape of the National Health Service during the 1940s; and (iv) the series of reports on nursing in the 1960s and in particular the Salmon report on senior nursing staff structure and its implementation. Each of these cases in its different way draws attention to constraints on the development of nursing as a profession; these constraints are discussed.

1760. BAUER, H. and KNOBLICH, K. Ein Beitrag zur Erfassung der Laufleistung stationär tätiger Krankenschwestern. **[Measuring the amount of walking done by nurses working in hospitals.]** *Zeitschrift für die Gesamte Hygiene*, Berlin, 1978, July, vol. 24, no. 7, pp. 539-541.

In order to determine the distances covered by qualified nurses while on duty, tests were carried out with the use of pedometers in two different types of ward. Measurements on eight nurses over a total of 22 shifts on a urological ward in a modern hospital gave an average of 6260 m.; ±660 m. per nurse per shift. On an intensive care unit in an older hospital building, for nine nurses over a total of 15 shifts, the average distance covered per nurse per shift was 8260 m.; ±1870 m. The amount of walking involved is considered to be reasonable.

1761. ELHART, D. and others. **Scientific principles in nursing.** 8th edition. St. Louis, C. V. Mosby, 1978, xix, 689pp. £7.95

This eighth edition emphasizes the application of the nursing process, based on effective problem solving, to the care of the patient attempting adaptation. The book is divided into seven units. Unit one considers nursing in relation to health services, the orientation to health care, the scientific principles and the nursing process. Unit two outlines methods of preparing to meet the patient's needs, unit three considers methods of planning the patient's nursing care; unit four outlines nursing interventions to support adaptation including comfort, rest and sleep, care, food, elimination, long-term illness and the dying patient; unit five discusses the administration of medications and therapeutic agents; unit six discusses the common situations that threaten adaptation—communicable disease, pain, surgical intervention, and wounds and wound healing. Unit seven outlines common medico-surgical conditions. An appendix includes: a glossary; abbreviations; a list of symbols and approximate equivalents; formulae for conversion; diagnostic tests table; emergency procedures; and common bandaging techniques.

OTHER PROFESSIONAL AND TECHNICAL STAFF

1762. JOHNSON, T. M. **Physician's assistants, their physician employers, and the problem of autonomy: consensus or conflict?** *Journal of Family Practice*, New York, 1978, March, vol. 6, no. 3, pp. 621-625.

An in-depth study of teams of physicians and physicians' assistants in practice reveals that there is greater consensus than conflict concerning the autonomy of the physician's assistant; that the level of physician's assistant autonomy is not related to salary nor to physician's assistant employment satisfaction; and that physician-employers who consider their physician's assistants to be more autonomous also feel that the quality of their lives has improved as a result of hiring an assistant.

ORGANIZATION AND ADMINISTRATION

See also Abstract Nos. 1755, 1840, 1850

1763. MASSON, S. **Administrator's collection, 1977 edition: selected current literature for the health care administrator.** Chicago, American Hospital Association, 1977, ix, 53pp. $2.50

This edition of the *Administrator's Collection* is a compilation of selected literature on administrative, financial, legal or regulatory aspects of health care delivery, and health manpower; and the organization, management, planning of hospitals, hospital departments and related health care institutions. The *Collection* is intended to help in the selection and acquisition of administrative literature for health science libraries and to promote the continuing education of administrative staff in health care institutions. A total of 551 Codes were reviewed and periodicals were selected from more than 900 current titles subscribed to from the collection of the American Hospital Association's Library.

1764. RUBIO, V. O. Critica de la gestion hospitalaria. **[Criticism of hospital management.]** *Policlinica*, Barcelona, 1978, June, no. 47, pp. 56-59, 61.

Hospital management in Spain today is far from being uniform and is, in fact, paradoxical. A system which is much more 'liberal' than that in the United States co-exists with a rigid and centralized social security system which may be compared with that of the USSR. A new approach may be expected as the country becomes more democratic. The author briefly examines various features of the current debate on the forms hospital management should take: public *versus* private hospitals; the hospital as an enterprise; indirect or direct control; regionalization; objectives; and doctors' remuneration.

1765. BAUMGARTEN, J. Rationalisierung im Krankenhaus. **[Rationalization in the hospital.]** *Krankenhaus-Umschau*, Kulmbach, 1978, June, vol. 47, no. 6, pp. 430-435.

Rationalization is not a once-for-all exercise but a continuing process. So far very

little has been done to solve the demarcation, co-ordination and evaluation problems associated with hospital rationalization measures. In the future medical and economic statistics and the use of econometric measures will play an increasing role. But it will always have to be borne in mind that humanitarian, ethical, sociological and medical factors, as well as economic aspects have to be evaluated. The success of rationalization is measured not by cost reductions alone but on a comparison between the success of medical and nursing activities and the expenditure. The main objective of all rehabilitation measures must be to improve the medical and nursing care of patients.

1766. Grundsätze für die Organisation der Krankenhausführung. **[Basic principles for the organization of hospital management.]** *Krankenhaus-Umschau*, Kulmbach, 1978, June, vol. 47, no. 6, pp. 427-429.

These recommendations for the organization of hospital administration in Western Germany were issued by the German Hospital Association in April 1978. They are intended to meet the requirements of the hospitals of today and of recent hospital legislation. The respective responsibilities of hospital authorities and of the management of individual hospitals are laid down. The various types of legal constitution under private, public and ecclesiastical law are listed and described.

1767. TUSLER, W. H. **Facility planning: a key to effective management.** *Hospital Forum*, San Francisco, 1978, May/June, vol. 21, no. 1, pp. 4-6, 34.

Traditionally facility planning has been a passive process, but today it is more dynamic, giving hospital staff an opportunity to rethink and evaluate their current procedures and methods, to test alternatives, and to examine methods used at other institutions. The steps in the planning process should consider: definition of goals; operational policy; current use; demographic projections; projected needs; projected use; functional options; functional systems; staffing requirements; major equipment; operational feasibility; needs; functional relationships; environmental needs; and the feasibility of the project. This orderly approach is important whether the institution is large or small.

1768. TOOMEY, R. E. and BRUUN, E. E. **Multihospital system minimizes management costs through centralized financial operations.** *Hospitals*, Chicago, 1978, June 16, vol. 52, no. 12, pp. 109-110, 112, 114.

Greenville (S.C.) Hospital System, (GHS), comprises nine health care facilities with a combined total of 1,118 beds. Following a study of the feasibility of centralizing its financial activities, the system adopted a combination of centralized and decentralized activities in October 1970. The central finance division involves three main areas of responsibility: the controller's functions, the treasurer's functions, and the internal auditing functions. These areas, which report direct to the director of finance/treasurer, are geographically and organizationally separate and distinct from the decentralized functions of each of the five business managers of GHS operating divisions. The responsibilities of the business managers, controller, assistant treasurer and internal auditor are described and the role of the computer in financial activities is outlined. The new structure has improved efficiency and avoided duplication of expensive, sophisticated equipment and services.

GOVERNING BODIES, COMMITTEES

1769. MARQUET, G. Problèmes posés par la sécurité incendie à un Directeur d'Hôpital. **[Fire security and the hospital administrator.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1978, June/July, nos. 393/394, pp. 45-48; summaries in English, German, Italian and Spanish, p. 48.

A review of the hospital director's legal responsibility for fire precautions, with particular reference to French law, is followed by a short study of the operational aspects, (most frequent sites and causes of fires, practical preventive measures), and of the financial aspects of fire precautions.

ECONOMICS OF HOSPITAL MANAGEMENT

See also Abstract Nos. 1751, 1752, 1773-1775, 1857, 1879

1770. FRIEND, J. H. **A reorganised medical division.** *British Medical Journal*, London, 1978, June 24, vol. i, pp. 1676-1678.

This report describes the reorganization of the hospital service in North Staffordshire in 1967 in order to get the Stoke on Trent medical division to use resources more efficiently. The North Staffordshire Royal Infirmary, with 97 general beds, and the City General Hospital, with 170 general medical beds, lie a quarter of a mile apart. The mix of patients in both buildings coupled with the random allocation of acutely ill patients throughout the wards imposed a heavy demand upon the nursing staff and made it difficult for medical staff to provide satisfactory care. As a preliminary to total reorganization of the service the physicians abandoned the allocation of beds to individual physicians and created three units offering different levels of care: (a) a high dependency unit (HDU), (b) an intermediate area, and (c) a planned investigation unit. The effects of the reorganization are described. The increased ease of work for medical staff resulted in improved patient care and nursing staff also found great benefits in the scheme. The true size of the problem of seriously ill patients also became clear: relatively few patients needed high dependency care, and those who did needed it for only a short time. It appears that many of the problems of emergency medicine seem to have been created by the dispersal of emergency admissions to many wards, and many of these difficulties have been removed by concentrating this work in specialist units.

1771. PHILLIPS, D. F. **Curbing the nation's appetite: the case for controlling demand.** *Hospitals*, Chicago, 1978, May 1, vol. 52, no. 9, pp. 68-70, 72-73.

Attempts to control the rising cost of health care have concentrated on the supply of services (costs, construction, staffing, etc.) with no concomitant limits being set on rising demand for capital-intensive and special services. If a debilitated health care system unable to respond to community needs is to be avoided, a more balanced approach to controlling supply and demand will have to be sought. Some of the conceptual, technical and operational problems that must be studied immediately if these actions are to be successful are discussed.

1772. REES, P. H. and others. **Medical care in a tropical national reference and teaching hospital: outline study of cost-effectiveness.** *British Medical Journal*, London, 1978, July 8, vol. ii, pp. 102-104.

A cost-effective analysis was carried out of the management of in-patients in three medical wards of the Kenyatta National Teaching Hospital, Nairobi, Kenya. During a 28-day prospective audit all admissions to the adult observation ward, intensive care unit, and one of the eight medical wards were analyzed, the costs of running each type of ward averaged on a yearly basis, and capital depreciation and staff costs assessed. The results indicated that patients with chronic diseases, such as rheumatic heart disease, were more expensive to treat than those with acute, curable illnesses such as malaria. It was concluded that the costs of providing treatment could not be reduced without affecting standards of medical care. The expense of running reference hospitals may also be justified by their function as teaching hospitals.

BED OCCUPANCY, ECONOMIC USE OF BEDS

See also Abstract Nos. 1771, 1872, 1882

1773. WYMELENBERG, S. **Aggressive utilization review shortens stays, lowers costs.** *Hospitals*, Chicago, 1978, May 1, vol. 52, no. 9, pp. 75-76, 78.

When compared with the other 34 hospitals in its area, the 311-bed Framingham (Mass.) Union Hospital has a shorter length of stay, lower average cost per patient and a greater number of admissions per bed per year. In achieving this record, the hospital has taken a positive approach to utilization review, which is reinforced by peer review. A utilization review committee was established in 1966, one of its first actions being to produce a 17-page booklet listing target discharge times for some 200 common diagnoses. Techniques introduced to improve utilization included: bulletin boards for displaying relevant information: medical record review; daily review of admissions by the review co-ordinator nurse; encouragement of staff co-operation; and discharge planning by the continuing care department beginning on the day of admission.

1774. HANCOCK, W. M., MARTIN, J. B. and STORER, R. H. **Simulation-based occupancy recommendations for adult medical/surgical units using admissions scheduling systems.** *Inquiry*, Chicago, 1978, March, vol. 15, no. 1, pp. 25-32.

Economic operation requires the correct number of beds to meet demand. Existing models for determining this number are inadequate because they are incompatible with contemporary admissions scheduling systems. This paper (i) examines the implications of the Poisson assumption at length; (ii) presents the simulation-based occupancy recommendations for planning used by the Bureau of Hospital Administration of the University of Michigan; (iii) outlines the effects of admissions scheduling with call-ins; and (iv) discusses the trade-offs between scheduling and calling in associated with an admissions scheduling system. Admissions scheduling with census restoring call-ins is able to achieve significant occupancy increases due to added control of the hospital system. The paper provides a basis for improved sizing of units which come under the assumptions used in the simulation, in contrast with other models which greatly overstate the required beds and greatly increase cost. The paper also provides evidence for the use of call-ins in a scheduling system and indicates that size is not an important factor in achieving optimum occupancy.

1775. LIND, J. H. **Excess bed capacity controversy: myths and realities.** *Hospital Progress*, St. Louis, 1978, April, vol. 59, no. 4, pp. 12, 14.

Massachusetts has two regulatory agencies that affect the bed supply: (i) the Determination of Need (DON) programme for planning; and (ii) the Rate Setting Commission, concerned with reimbursement. Both aim to reduce the number of beds but use different methods of calculating excess. The two major cost reports are related to patient days rather than the number of beds and little is saved by removing an empty bed. Disallowing bed replacement plans may produce short-term savings but will result in long-term inefficiencies. To make systems like DON effective, modern facilities rather than cheaper alternatives are needed.

1776. EDWARDS, R. C. **Professionals in 'alliance' achieve more effective discharge planning.** *Hospitals*, Chicago, 1978, June 1, vol. 52, no. 11, pp. 71-72.

Methodist Hospital, Madison, Wisc., uses an alliance of health care professionals for discharge planning under its programme of quality assurance. The programme is built on a primary alliance of social workers and patient care co-ordinators (registered nurses accountable to the physician co-ordinator of the current review programme). The four major components of the programme are identification, needs assessment, service co-ordination, and follow-up. Brief details are given of each.

APPOINTMENT SYSTEMS, WAITING LISTS

1777. JONES, F. A. and MCCARTHY, M. **Understanding waiting lists.** *Lancet*, London, 1978, July 1, vol. ii, no. 8079, pp. 34-36.

There are a number of reasons for the existence of hospital waiting lists, but overall the National Health Service has achieved much and the problem needs better understanding. A more accurate picture of the pressures on hospitals is achieved by studying the waiting time between the first out-patient appointment being made and treatment being received. The number of patients sent to a hospital depends upon the size of the population and the supporting services available in any one area. Arrangements for making out-patient appointments need to be reviewed regularly in an attempt to ease the workload. Admission systems described, with their advantages and disadvantages include: (i) a centralized admissions system; and (ii) an admissions book. The recent practice of day- and short-stay care and changes in treatment have produced an increase in available beds in certain named areas, notably psychiatry and rheumatology. However, there is still much unmet need, and better statistics of waiting times at both national and regional level are required.

ELECTRONIC DATA PROCESSING

See also Abstract Nos. 1747, 1780-1782, 1784, 1845, 1848

1778. GRIESSER, G. **Data security—a challenge to medical informatics.** *Medical Informatics*, London, 1978, June, vol. 3, no. 2, pp. 71-75.

The introduction of computerized health information systems has been regarded as a threat to the patient's right of privacy and the doctor's duty of confidentiality. Staff

trained to use such systems must observe certain data protection measures. These include: (i) establishing the information system as a self-contained entity; (ii) not giving data to outside agencies to be processed; (iii) providing a list of users and their rights of access; (iv) careful initial planning of the system; and (v) permanent auditing of data security. The most important factor is the user's right of access to data and the method by which this right may be exercised. Protection measures must also take into account the possibility of malicious intrusion. The International Federation for Information Processing has been set up to deal with data protection on an international level.

LIBRARIES

1779. MUNDT, J. L. **Hospital libraries' consortium blunts impact of budget cuts.** *Hospitals*, Chicago, 1978, June 1, vol. 52, no. 11, pp. 75-76, 78.

Faced with increasing costs for journals and other educational resources, increasing demand, and decreasing budgets, several medical and hospital libraries in Illinois have formed a consortium that emphasizes sharing of resources, inter-library loans, librarian consultation services, and cost-saving projects. The Illinois Health Libraries Consortium, formed by the Health and Hospitals Governing Commission, Chicago, began with five members and has grown to include 21 members in its four years of operation. The development of the consortium and its functions are outlined.

ORGANIZATION AND METHODS, WORK STUDY

See Abstract No. 1854

MEDICAL RECORDS

See also Abstract Nos. 1778, 1823

1780. HEAULME, M. de and ANDERSON, J. **Creation and validation of medical data.** *Medical Informatics*, London, 1978, June, vol. 3, no. 2, pp. 137-144.

This paper deals with the problems which occur when physicians use computers for data entry and analysis. Data are provided by medical staff who usually require an on-line response. The complete record must be considered, including retrieval, interrogation, reports and analyses relating to administrative, clinical and research needs. Difficulties may arise at any one of these stages. The collection of data and its structuring for computer use must be handled by competent staff. Before storage, data must be validated by checking and verifying the content, as errors may have serious consequences for patients. Both senior and junior medical staff must be well trained in validation. Without valid data most analyses are useless, owing to the high error rates and/or too much missing material.

1781. ROGER, F. H. and others. **Problem-oriented medical records according to the Weed model.** *Medical Informatics*, London, 1978, June, vol. 3, no. 2, pp. 113-129.

The problem-oriented medical record devised by L. L. Weed aims to provide a

system which uses the medical record to provide a comprehensive approach to the patient. However, users have found that: (i) the problem concept causes confusion; (ii) organization of data under a "problem" list biases the medical information; (iii) when computerized the system does not allow the patient and his problem to be placed in his community; and (iv) the system merely supplements the physician's memory. The Department of Internal Medicine at the Catholic University of Louvain has developed what is termed an "explicit integrated medical record". This includes: (i) a problem list where patient problems, including social data, are distinguished from medical problems; (ii) an approach to problems with the aim of making decisions about treatment; and (iii) a clinical summary which can be approached from several viewpoints. The system links information about patients and locates their problems in a wider setting.

1782. YOUNG, D. W. **A problem orientated information system.** *Medical Informatics*, London, 1978, June, vol. 3, no. 2, pp. 105-111.

It has been suggested that the care of patients with medical problems is not always consistent, especially in emergency cases. The House Officer Information and Scheduling System (HOISS), in operation at St. Chad's Hospital, Birmingham, is described. It consists basically of a set of programs with access to a data-base of information on 80 clinical problems. The system prints out an information sheet for each problem and a worksheet of tests needing to be done. A review of the care given to 86 patients revealed a considerable variation in the investigations made and the tests requested for any one problem. Five months of using HOISS resulted in more consistent patient management and more regular routine tests.

1783. FERNOW, L. C. and others. **The effect of problem-oriented medical records on clinical management controlled for patient risks.** *Medical Care*, Philadelphia, 1978, June, vol. 16, no. 6, pp. 476-487.

This study examines the changes in clinical management in three London teaching hospitals following the introduction of Problem-Oriented Medical Records (POMR) in one of the hospitals. Comparison is made between those surgical and medical firms using and those not using POMR. The data are analyzed using a regression model; the analysis is based upon the coefficient of change between the two study years. The results in four of the seven diseases studied encourage the speculation that POMR may have encouraged the thoroughness of patient management. The significant patient variables in each diagnosis suggest that patient risk on admission can affect management scores. If this were found elsewhere the influences of patient mix might be considered in using explicit criteria to make comparisons between hospitals that serve different kinds of population.

1784. SHAFFER, M. J. and others. **Manual record-keeping and statistical records for the operating room.** *Medical Instrumentation*, Arlington, Va., 1978, May/June, vol. 12, no. 3, pp. 192-197.

Surveys have shown that handwritten anaesthesia and circulating records kept in operating theatres may be inadequately maintained and analyzed. On-line, fully automated data processing techniques have been applied to reduce the anaesthetist's record-keeping work load, but with limited acceptance. George Washington University

Hospital, Washington, D.C., has developed an off-line data processing system using handwritten records to provide both anaesthesia and operating theatre use statistics. A seventh sheet to the anaesthetic record uses an alphanumeric code; the information on it is subsequently punched in Hollerith cards for batch processing on an IBM 370 computer. A Varian 620 mini-computer is used to produce a monthly statistics report from the circulating records. Evaluation of the system indicates that an on-line semi-automated approach applied only to charting vital signs and recording use statistics is an appropriate one for future development.

1785. LONGABAUGH, R., editor. **The problem-oriented medical record and system.** *International Journal of Mental Health*, White Plains, N.Y., vol. 6, no. 2, pp. 3-121.

Since the basic principles of the application to psychiatry of the problem-oriented approach to medical records were first documented in 1972, considerable interest in the system has been shown by the mental health professions. The primary purpose of this group of papers is to describe some of the applications of the system in psychiatry; a secondary purpose is to give a current evaluation of its merits and demerits. Following an introduction there are papers on: the value of the problem-oriented record in psychiatry; adaptation of the system at Butler Hospital, Providence, R.I.; use of the system in the psychiatric department of a community general hospital; the structured interview as an aid to compiling a clear and concise data base; computerized behavioural assessment and the problem-oriented record; a critical analysis of record-keeping procedures; the problem-oriented record in quality review, programme planning and research; a normative model for problem- and goal-oriented therapeutic intervention; and current status and perspectives.

HOSPITAL STATISTICS

See Abstract Nos. 1832, 1874

LEGAL ASPECTS OF HOSPITAL ADMINISTRATION

See also Abstract Nos. 1778, 1792, 1833, 1858

1786. BARBER, B., editor. **Medical ethics and social change.** *Annals of the American Academy of Political and Social Science*, Philadelphia, Penn., 1978, May, vol. 437, pp. 1-141.

This is a series of 12 papers on various aspects of medical ethics in the United States. Medical ethics are in a period of transition, and the patterns, causes, agents, modes, resistance to and costs of carrying out these changes are outlined. These are further related to the detailed studies presented on: informed consent; professional monopoly; social conditions; medical care systems; dilemma of the critically ill patient; drug research; the law; human experimentation; and epidemiology.

1787. HORAN, D. J. **Right-to-die laws: creating, not clarifying, problems.** *Hospital Progress*, St. Louis, 1978, June, vol. 59, no. 6, pp. 62-65, 78.

In 1977, eight states in the United States passed legislation described as natural

death or living will acts and more than 59 other bills are pending in 42 States. The author analyzes the eight acts in an attempt to determine whether or not such legislation helps the problem of ending treatment given to terminal patients. The author considers that none of the laws serve to clarify existing legislation, nor do they make the issue of voluntary consent any easier. All states make it clear that a directive to withdraw treatment signed by the patient or in some cases his representative, can only become effective when the patient is in a terminal condition, but in Arkansas, the law is less specific. The author considers that the natural death laws inhibit rather than help the physician to deal with the dying patient and that they represent an intrusion into the patient-physician relationship.

FINANCE AND ACCOUNTING

See also Abstract No. 1768

1788. LIGHTLE, M. A. **'70s see new approaches to capital financing for hospitals.** *Hospitals*, Chicago, 1978, June 16, vol. 52, no. 12, pp. 135-136, 138, 140, 142.

In the post-war years and throughout the late 1960s, capital financing for hospitals in the United States was provided primarily by philanthropy, grants and internal reserves. In the past 10 years or so, several events have occurred that have had a profound effect on capital formation in hospitals. These include: the implementation of the Medicare and Medicaid programmes; areawide planning; and new debt financing methods, including tax-exempt bonds, mortgage insurance, taxable bonds and notes, farmer's home administration and Hill-Burton direct loans or loan guarantees.

1789. STEINERT, J. H. **Can hospitals survive payment shortfalls?** *Hospitals*, Chicago, 1978, June 16, vol. 52, no. 12, pp. 125-126.

Revenue losses for United States hospitals have increased with the passage of Medicare and Medicaid legislation and are now imposing heavy demands on their financial resources. On the national level, hospitals have sought to cope with new programmes and methods of operation, including shared services and multi-unit systems. On the individual level, hospitals can do little to alleviate payment shortfalls. Efforts should be aimed at a proper classification of patients and improved accounting systems. Careful attention should be paid to Medicare and Medicaid reimbursement regulations, and sponsors should be sought for charity patients. Hospitals should also lend their support to local and national associations working for more adequate reimbursement.

COSTS

See also Abstract Nos. 1737, 1775, 1779, 1789, 1865, 1879

1790. THOMPSON, G. B. and CANNON, W. G. **Hospitals, like industry, must apply cost accounting techniques.** *Hospitals*, Chicago, 1978, June 16, vol. 52, no. 12, pp. 129, 131-132.

The failure of hospitals to adopt the cost accounting used in industry is discussed. A simplified cost-accounting model representing a typical business entity is presented and related to the hospital. The need for hospitals to install managerial accounting and

performance measurement systems is stressed. The system should be based on the principle that there is a relationship between the volume of a specified function in a hospital and the behaviour of costs associated with that function. With this principle established, the system should be constructed to include four major components: units of measurement, standards, performance reporting, and planning and budgeting.

1791. HYMAN, C. A. **California hospitals find success with uniform billing.** *Hospitals*, Chicago, 1978, June 16, vol. 52, no. 12, pp. 165-166, 170.

To test whether a universal billing form would, in fact, cut paperwork and provide greater processing efficiency, California hospitals and third-party payers launched a campaign on 1 January 1976 to standardize billing procedures. Now, after more than two years, about 83 per cent of California's 650 health care facilities are using the standard form. The programme took more than seven years to evolve. While it is too early to evaluate cost savings from the programme, an informal survey of a cross-section of hospitals indicated that it had: (i) eliminated the need for cross-training billing staff thereby enhancing staff effectiveness and productivity; (ii) enabled hospitals to provide more information to third-party payers; (iii) simplified invoices for patients' understanding; (iv) allowed benefits to be more easily co-ordinated among several insurance companies; and (v) given hospital staff and patients transferring from one facility to another within the state the advantages associated with uniform billing practices.

1792. BROMBERG, R. S. and TRULY, E. **Tax and medicare aspects of hospital malpractice insurance.** *Hospitals*, Chicago, 1978, May 1, vol. 52, no. 9, pp. 64-67.

Any discussion of tax exemption for malpractice insurance associations must begin by recognizing that, although the tax-exempt status of certain forms of associations should eventually be recognized by the courts or Congress, there will be considerable resistance from the Internal Revenue Service. For this reason the authors concentrate on: (i) the various possibilities for exemption under the present Internal Revenue Code—charitable, social welfare, and business league or professional association; (ii) the position of the Internal Revenue Service with respect to these different modes of exemption; and (iii) the types of arguments that can and should be made to support a claim for exemption.

SUPPLIES AND STORES

PURCHASING

See Abstract No. 1844

CATERING, DIETETICS, KITCHENS

HOSPITAL CATERING

1793. **Southampton General Hospital: centre block catering complex.** *Hospital Development*, London, 1978, May/June, vol. 6, no. 3, pp. 20-22.

The new catering complex at Southampton General Hospital is part of a rebuilding

programme which started 10 years ago and is due for completion in 1984. New staff dining facilities have been phased in to link with the three-year old production kitchen and patients' service area operating a Ganymede central tray service. The dining area has been split into five areas: reception, salad bar, coffee lounge, main dining area and specialist waitress restaurant. Brief details are given of each area, the kitchen and the central wash-up areas. A plan is included.

1794. UNKLESBAY, N. **Hospital foodservice—1978 and beyond.** *Journal of Food Protection*, Ames, Ia., 1978, June, vol. 41, no. 6, pp. 471-475.

This paper discusses how changes within the health care and food processing industries have influenced the development of alternative food service systems, and projects some future trends related to resource usage. Schematic diagrams for four alternative food service systems are presented and discussed. Research activities related to the quality and safety of foods within each of these systems have been limited. In addition these systems evolved without adequate consideration of effective use of energy resources. In the future, food processors and food service managers will have to co-ordinate their work in order to produce good quality, energy-efficient menu items.

1795. HUNWICK, H. **Ready to order?** *Dimensions in Health Service*, Ottawa, 1978, June, vol. 55, no. 6, pp. 29, 40.

The menu system at the Queensway Carleton Hospital, Ottawa, comprises a modified hotel type menu with a 10-day cycle based on convenience foods and providing a 'Special of the day' at each main meal. A check sheet was designed for use in the daily collection of patients' choices. Four master therapeutic menus, with colour coded check sheets, were devised: (i) general; (ii) soft; (iii) low sodium; and (iv) calculated. Education in the system for both patients and dietary and other staff was a great advantage. Surveys have shown that the new system has led to: (i) improved patient satisfaction; (ii) improved patient nutrition; and (iii) the provision of an educational tool in encouraging healthy choices, especially in the case of therapeutic diets. Full cost comparisons still have to be made, but the new system has contributed to the smoother running of the dietary department.

1796. Maaltijd onderverdelen in assortimentsgroepen: combineren van componenten verschillende menu's vergroot aantal keuzemogelijkheden: eisen menuplan vooraf vaststellen. **[Meal subdivision into groups of products: combining various menu components increases menu choice possibilities: demand for menu pre-planning.]** *Voeding-en Huishoudgids*, Amsterdam, 1978, June 26, vol. 45, no. 547, pp. 331, 333.

Menu planning in cycles of weeks, months or a year, forms the basis of catering organization and includes purchasing, production and staffing. When designing menus account must be taken of the nutritional requirements of a meal, its cost, frequency of presentation and combination of colour, consistency and calorific value. The aim (of the institutions participating in the NOR-project) is to present to the patients a selection of different menus out of which individual dishes can be interchanged, thus providing a wide variety of choices. Special requirements, such as special or light diets, have to be decided on by each institution individually, and in order to maintain a good nutritional balance, patients should be given information and advice. Details on menu planning are being published in a series of NOR-project reports.

DIETETICS IN THE HOSPITAL

1797. CARSON, J. A. S. **Nutrition in a team approach to rehabilitation of the patient with cancer.** *Journal of the American Dietetic Association*, Chicago, 1978, April, vol. 72, no. 4, pp. 407-409.

The nutritionist in the cancer rehabilitation team at the University of Texas Health Science Center at Dallas helps patients to solve dietary problems related to the treatment they are receiving. Weight maintenance during a radiotherapy course and the establishment of a suitable diet for a colostomy patient are two of the problems dealt with. The nutritionist benefits from the services given to the patients by other members of the team and can, in turn, help other members by drawing attention to a variety of physical problems and by providing basic nutritional information.

1798. ELLIOT, E. and others. **A survey of dietitians' work in hospitals in the United Kingdom.** *Journal of Human Nutrition*, London, 1978, June, vol. 32, no. 3, pp. 187-193.

A working party of the British Dietetic Association carried out a survey to determine where National Health Service dietitians are working and how they divide their time between the two major roles of nutrition advice and provision of special diets. The results showed that Wales, Northern Ireland, Scotland, the North East Thames and the Northern Regions are under-supplied. The dietitian's day may be divided between up to six or seven activities, but most time is spent with patients. The teaching districts employ 44 per cent of all dietitians, and these, especially the more junior, are more likely to spend time in the kitchen. The dietitian's role is being changed by: (i) the profession's insistence on an advisory role; and (ii) changing ideas about therapeutic diets. These changes, together with the facts revealed in the survey, should encourage a review of both dietetic work and the appropriateness of present training.

FOOD SERVICE

See Abstract No. 1794

LAUNDRIES AND LINEN SERVICE

HOSPITAL LINEN AND TEXTILES

See Abstract No. 1808

HOSPITAL DOMESTIC MANAGEMENT

1799. THORLEY, S. **A report on an evaluation of the domestic services training kit.** [London, Department of Health and Social Security], 1977, [ii], 42pp.

This report evaluates the kit for the training of domestic supervisors first established in November 1974. The kit consists of 16 manuals for consecutive issue to and study

by course members for use at 16 study days held at approximately two-weekly intervals, with the aim of enabling as many domestic services staff as possible to receive economic, effective and systematic training over a wide range of their duties. The report considers: the concept and method; the 'Cascade' effect at the various levels and consumer reaction; the training kit; reports from Regions. It includes six appendices which cover: techniques and research instruments; sample statistics; national briefing responses; supervisor's quiz results; the end of course questionnaire; and the position of the Regional Training Programmes at December 1976.

DOMESTIC WORK

See Abstract No. 1803

HYGIENE IN THE HOSPITAL

SOURCES OF INFECTION

See also Abstract No. 1804

1800. MOLINA, L., D'AQUINO, B. and VLACOS, D. L'epatite virale nel personale ospedaliero: aspetti igienici e medico-sociali. **[Viral hepatitis in hospital staff. Aspects of hygiene and social medicine.]** *Ospedale*, Torino, 1978, May, vol. 31, no. 5, pp. 123-129.

Between 1972 and 1976, 48 members of the staff (between three and five per cent each year) in a hospital in Pavia were affected by viral hepatitis. Twenty of these worked in the internal medicine unit; 11 were doctors and 32 were nurses. The authors list the prophylactic measures to be observed in the hospital in order to prevent transmission of this disease and present the results of tests for the Au antigen in hospital staff. Finally, there is a discussion on whether viral hepatitis should be considered as an occupational disease for insurance purposes.

PREVENTION AND CONTROL

See also Abstract Nos. 1800, 1806

1801. BOLWINKEL, T. and others. Hygiejnekomiteen for Fyns Amts Sygehusväsen. **[Organization and function of the Fyn County Hospital Service Hygiene Committee, 1976-78.]** *Tidsskrift for danske Sygehuse*, Glostrup, 1978, June/July, vol. 54, no. 6, pp. 100-101.

Since 1975, counties have been responsible for hospital hygiene committees and the maintenance of hygiene standards. Their responsibilities comprise: (i) clinical microbiological services (advice on the diagnosis and treatment of individual patients) and public institutions; (ii) staff training; and (iii) epidemiology. The County of Fyn (Funen) set up its hygiene committee in 1976, and has held seven meetings in two years. The 23 members of the committee are drawn from County Treasury (1), the 12

hospitals (14), the two colleges of nursing (2), the Matrons' council (1), central pharmacy (1), the Department of Clinical Microbiology (2), the Medical Officers of Health (1) and the County health nurse (1). There are five sub-committees, responsible for: (i) hospital hygiene; (ii) preparation and amendment of detailed hygiene instructions (15 meetings); (iii) teaching aids advice (8 meetings); (iv) staff instruction (7 meetings); and (v) disinfection (work performed by questionnaire). The committee enjoys the full support of the county authorities and the nursing staff, and is seeking the establishment of a full-time County Hygiene Nurse to assist the part-time hygiene nurses in the individual institutions. The article is illustrated with a block diagram showing the structure of the committee and its sub-committees, and includes the address of the secretariat.

1802. VAUGHAN, R. S. **Theatre pollution and its possible effects on personnel.** *NATNews*, Matlock, 1978, June, vol. 15, no. 6, pp. 16-18.

Whether there are health risks involved in exposing operating theatre staff to anaesthetic agents is debatable, but it is obviously wise to avoid operating room contamination. This can be done by: (i) reducing the gas flow from the anaesthetic machine and using closed-circuit anaesthesia; (ii) using passive scavenging to deflect expired gases away from the operating table by means of lengths of tubing; and (iii) using active scavenging, with an additional force to draw away expired gases to a discharge point. The anaesthetist should use the minimum safe fresh gas flow and anaesthetic machines should be carefully checked for leaks. Even when precautions are taken, the levels of anaesthetic concentration in the operating rooms should be monitored regularly. Theatre nurses should be aware of the possible risks of contamination with regard to pregnancy.

1803. **Mopping up a hospital's cross-infection.** *Cleaning & Maintenance*, London, 1978, June, vol. 26, no. 6, pp. 25-26, 29.

At Poole General Hospital, Dorset, investigations were carried out into the cleaning equipment used in operating theatres after a number of post-operative patients suffered wound infections. Swab tests on the mops and buckets used showed a high level of pseudomonas contamination. A mop supplied with different coloured cellular foam heads was tested and was found to autoclave without damage and to dry quickly. The mops were put into use in the five operating suites, with buckets colour-coded to match. The mop is now used to clean vinyl floors in wards. While not standard practice in hospitals, autoclaving of mops is strongly recommended as an extra safeguard against cross-infection.

1804. WINKELMANN, U. Hygienemassnahmen zum Schutze der Patienten aus der Sicht des Pflegedienstes. **[Measures of hygiene for the protection of patients from the point of view of the nursing service.]** *Krankenhaus-Umschau*, Kulmbach, 1978, June, vol. 47, no. 6, pp. 435, 437-439.

Whilst measures to prevent infection are adequate, and usually observed, in areas of special risk (e.g. operating suites), the situation in other areas is often far from satisfactory. Examples are given: (i) the use of the same lift for clean and dirty materials and for newly-operated patients as well as staff; (ii) careless treatment of dirty linen on wards; (iii) inadequate hand washing and disinfection by nurses passing from

patient to patient; and (iv) insufficient use of disposables. All hospital staff should be trained in hygiene and should have refresher courses. Responsibility for hospital hygiene should rest with a senior staff member who should not take on this task as a subsidiary duty. The cost of adequate control of hospital hygiene is admittedly considerable but the cost of inadequate hygiene measures could be greater.

1805. LOWELL, J. D. and KUNDSIN, R. B. **The operating room and the ultraviolet environment.** *Medical Instrumentation*, Arlington, Va., 1978, May/June, vol. 12, no. 3, pp. 161-164.

Clean surgical wounds may be contaminated from three separate sources: (i) endogenously, from the patient himself; (ii) exogenously, from direct contamination by unsterile instruments, drapes, gowns, hands or gloves; and (iii) by bacteria settling from the air over the operating field. The advent of total joint replacement precipitated a new consciousness of the disastrous consequences a wound infection can have upon orthopaedic patients. Deep infection around a total joint replacement can convert a procedure with a 95 per cent probability of success into a total disaster, leaving the patient worse than prior to operation. Most orthopaedic surgeons use two accepted methods of preventing post-operative wound infection: topical antibiotics during surgery and intravenous infusion of systemic antibiotics during and after surgery for a brief period. In addition, many operate in clean air rooms with total body exhaustion or in an ultraviolet environment. Use of the ultraviolet environment at the Brigham hospitals since 1973 has resulted in a drop in the infection rate in a series of 2,000 patients from 3.8 to 1.04 per cent. However, inconveniences and hazards have been experienced in the use of ultraviolet irradiation in the operating theatre.

HYGIENE IN THE OPERATING THEATRE

See also Abstract No. 1805

1806. LAUFMAN, H. **Design, devices, and discipline in operating room infection control.** *Medical Instrumentation*, Arlington, Va., 1978, May/June, vol. 12, no. 3, pp. 158-160.

The prevention of surgical infection in the operating theatre is a complex pursuit. Every facet of activity, whether it is part of the surgical act itself or a remote activity with indirect effects on the surgical operation, constitutes part of the whole realm of infection control. These many facets may be divided into four main components, all interdependent: (i) the surgeon and his team (surgical technique, adherence to surgical anatomical, physiological and aseptic principles, and discipline); (ii) education and communication (through the work of the infections committee, repeated tutorials, constant review of methods and systems, effective reporting of offences, and enforcement of discipline); (iii) dependable support services (sterilizing techniques, barrier materials, clothing, laundry methods, materials handling and processing methods, efficiency and personal hygiene, and discipline); and (iv) the environmental factors (architecture, engineering, air handling, electrical and mechanical requirements, communication and discipline).

STERILIZATION

See also Abstract Nos. 1803, 1851

1807. MORANDINI, M. and SALVADOR, P. Sterilizzazione ospedaliera. **[Hospital sterilization.]** *Tecnica Ospedaliera*, Milano, 1978, March, vol. 8, no. 3, pp. 66-72.

This is the last of a series of articles on sterilization (see Hospital Abstracts, vol. 18, Abstract Nos. 1031, 1186, 1348). The systems for transferring articles to and from the operating theatre and central sterilizing unit are analyzed. The authors recommend that when a central sterilizing system is being installed, the foreseeable demands of all future users should be considered and that, where possible, the dimensions of the containers be standardized with those used in the hospital's internal automatic transport system.

1808. HULTMAN, D. P. and others. **Measurement of critical properties of muslin and non-woven sterile-wraps.** *Medical Instrumentation*, Arlington, Va., 1978, May/June, vol. 12, no. 3, pp. 174-176.

Empirical evaluations closely simulating actual use conditions were used to compare critical property levels of commonly used muslin (140-thread) and non-woven sterile wraps used to pack items to be sterilized. Critical properties and experimental methods used to measure these properties were: (i) ease of steam penetration, determined by time-temperature measurements in large, double-wrapped packs subjected to steam sterilization; (ii) effectiveness as a barrier to bacteria, measured by microbiological assay of initially sterile double- and single-wrapped pack contents after storage in hospitals; (iii) compatibility with ethylene oxide sterilization measured by inactivation of spare strips and by quantities of residual ethylene oxide after aeration of packs; and (iv) generation of lint, by counting particles generated by flexing wrap materials. It was concluded that the non-woven sterile wrap was superior in ease of steam penetration, bacterial barrier and linting. No difference was detected between materials in ethylene oxide sterilization.

1809. AULAGNER, G., JOLIVET, A. and LEDUC, V. Mise en place d'une nouvelle stérilisation dans un hôpital de 2,400 lits. **[Installation of a new sterilization unit in a hospital of 2,400 beds.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1978, May, no. 392, pp. 65-77.

The new sterilization unit in the 2,400-bed Édouard-Herriot Hospital in Lyons replaces one which was installed in 1934. The mode of operation of the new unit is described: products are automatically packed in individual paper bags which are then placed in one of the two autoclaves. The central sterilization unit is responsible for the sterilization of dressings, textiles (linen and clothing), and a few instruments, also the distribution of sterile material and the distribution of equipment for dressings, whether sterile or not. Most instruments are sterilized in the operating blocks or in individual departments. The central unit covers an area of 550 square metres and includes a non-sterile store, a preparation room, and a 'clean' store. The reasons for the decision to have a unit of this kind are explained and the authors describe at length how the decision was reached. The organization of the unit, the duties of the various members of staff, and methods of stock management are also described. The article includes five tables, two diagrams, one graph, a plan of the unit, and a sample re-ordering form.

DISPOSAL OF WASTE

1810. NORRIS, F. S. **Medical waste disposal: to burn or to landfill?** *Hospitals*, Chicago, 1978, May 1, vol. 52, no. 9, pp. 111-112, 114, 117-118.

Conflicting regulations on and varying definitions of medical wastes and their disposal have long been a source of confusion for health care institutions attempting to resolve the problem. Guidelines recently drafted by Maryland Department of Health and Mental Hygiene define three categories of waste: general solid wastes; medical/pathological wastes; and other special wastes. On-site incineration is the preferred and in some cases the only acceptable method of disposal; landfilling at public dumps and off-site incineration are also used. Incinerator technology has advanced to the point where available incinerators are economically and ecologically feasible. The attachment of a heat recovery unit can result in even more savings. Brief details of some incinerator installations are given.

SAFETY MEASURES

See Abstract Nos. 1743, 1852

ACCIDENTS, GENERALLY

1811. LIEBKNECHT, W. L. Tuberkulosegefährdung des ärztlichen Personals. **[Danger of tuberculosis infection among medical personnel.]** *Deutsche Medizinische Wochenschrift*, Stuttgart, 1978, Aug. 4, vol. 103, no. 31, pp. 1237-1240.

According to statistics from Augsburg covering the years 1973 to 1976, hospital staff (including doctors, nurses and cleaners) are 40 to 100 times more likely than the general population to become infected with pulmonary tuberculosis. More than 90 per cent of young adults have no immunity to tuberculosis and are particularly at risk when working in hospitals. Tuberculosis in hospital staff should be regarded as an occupational disease if there has been no previous infection and no source of infection outside the hospital can be demonstrated. There should be selective BCG vaccination for all staff working in the health services.

ACCIDENTS IN GAS AND DRUG ADMINISTRATION

See Abstract No. 1838

FIRES AND FIRE PREVENTION

See also Abstract Nos. 1743, 1769

1812. SANYTR, A. Brandschutz in Spitälern. **[Fire protection in hospitals.]** *Mitteilungen der Österreichischen Sanitätsverwaltung*, Wien, 1978, June 15, vol. 79, no. 6, pp. 147-149.

This is the text of a talk given by the director of the Vienna Fire Service to medical

officers on a training course. It is concerned with the measures necessary to prevent serious fire outbreaks in hospitals. Such measures are bound to cause difficulties and even unpleasantness (e.g., limited use of Bunsen burners, restrictions on smoking, storage of flammable fluids in the smallest possible containers, a ban on the use of risky synthetic textiles) but are of the greatest importance. Staff instruction on the basis of a detailed fire plan including siting and use of extinguishers, giving the alarm, and the care and movement of patients is also essential.

PLANNING FOR MASS EMERGENCIES

1813. FRIEDMAN, E. **Updating disaster plans: a tale of three hospitals.** *Hospitals*, Chicago, 1978, May 1, vol. 52, no. 9, pp. 95-96, 98, 100-102.

This paper describes the changes made to their disaster plans by three hospitals which experienced actual disasters in 1977. Lee Hospital, Johnstown, Pa., is now installing a tough 'floodproofing' system following a flood which entered basement areas and destroyed many primary electrical and emergency systems. During the New York City blackout of 1977, emergency electrical generators failed at Jewish Hospital and Medical Center, Brooklyn, and at Bellevue Hospital Center, Manhattan. Steps now taken at both these hospitals to ensure that standby generators are always in working order are outlined.

THE PATIENT

1814. ROSS, H. E. and KEDWARD, H. B. **Social functioning and self-care in hospitalized psychogeriatric patients.** *Journal of Nervous and Mental Disease*, Baltimore, 1978, vol. 166, no. 1, pp. 25-33.

Evaluations of social disability have been found useful in determining factors of diagnostic, therapeutic and prognostic significance in the management of psychogeriatric patients. A random sample of 100 psychogeriatric patients aged 65 and over admitted to three Toronto hospitals was studied prospectively. Standardized clinical and social interview schedules were used to assess patients' mental states, self-care capacity, social isolation, burden on the family, and household contribution before admission. These assessments were carried out to determine their significance with respect to diagnosis and outcome. Social isolation was correlated significantly with length of hospital stay. Burden of the family was not found to be related significantly to diagnosis or outcome, although there was a tendency for patients with organic disorders to present more difficulties for their families. The severe burden imposed on relatives suggests the need for use of community social and medical services to provide relief for families. The implications of the findings for management are discussed.

ADMISSION AND RECEPTION

See Abstract No. 1872

WELFARE OF THE PATIENT

See also Abstract Nos. 1754, 1787, 1834, 1867, 1886

1815. SCHRAMER, T. Krankenpflege aus der Sicht des Patienten. **[Nursing from the patient's point of view.]** *Deutsche Krankenpflege-Zeitschrift*, Stuttgart, 1978, June, vol. 31, no. 6, pp. 279-281.

In this paper a nurse looks at the disadvantages of a stay in hospital from the patient's point of view: the restricted movement; 'depersonalization' (he can become an 'illness' or a 'case' rather than a human being); dependence on medical and nursing staff; being treated like a child; subjection to discipline; and being cut off from his normal environment. The patient must be treated as a whole human being and he must be the centre of all activity. The hospital should not be regarded as a health factory or a repair workshop for the human machine. Patient-centred nursing care has four basic tasks: to alleviate suffering; to promote health; to prevent illness; and to restore health.

1816. HINTHORNE, R. A. and JONES, R. **Co-ordinating patient education in the hospital.** *Hospitals*, Chicago, 1978, June 1, vol. 52, no. 11, pp. 85-86, 88.

As a result of duplication of effort and material for patient education at the Veterans Administration Hospital, Spokane, Wash., a patient education committee was established in December 1976. The memorandum establishing the committee outlined its policy and responsibilities. The committee is chaired by a physician and its members include representatives of the medical and nursing staff and library services. The committee has been vital in co-ordinating patient teaching efforts and has been able to eliminate duplication of resources. Some of the teaching programmes developed are mentioned.

1817. ROSEN, A. L. **Patient education programs: where are the social workers?** *Health and Social Work*, New York, 1978, May, vol. 3, no. 2, pp. 175-181.

Efforts to educate hospital patients to participate actively in their own health care have increased in the last decade. Studies show that existing programmes are disease/illness oriented, that is corrective rather than preventive. This fact is shown clearly by the less frequent use of social workers in these programmes as compared with other health professionals. Social workers can and should play an integral part in developing patient education programmes in hospitals because: (i) they may increase the quality of communication between patient and educator; (ii) they have available the evaluative and research tools which are lacking at present; (iii) they can increase the possibilities for case identification; and (iv) the image of social workers could be improved by their participation.

1818. MOORE, R. M. **Consent forms—how, or whether, they should be used.** *Mayo Clinic Proceedings*, Rochester, 1978, May/June, vol. 53, no. 5/6, pp. 393-396.

This article points out the major benefits and potential problems of consent forms and suggests how such forms may best be used. A clearly worded consent form is the most satisfactory way for a physician to obtain informed consent to treatment from a

patient, thereby protecting his interests in any subsequent claim the patient may make. The task of asking the patient to sign the form should never be delegated and should be preceeded by a frank discussion between patient and physician. The form should: (i) give a clear outline of the risks involved in treatment; (ii) avoid complex medical terms; (iii) be approved by a lawyer; and (iv) exclude legal stipulations. The correct use of forms is particularly important in cases of elective surgery. The use of consent forms may not always be practical in a large hospital or clinic, and where this is so the recorded discussion with the patient assumes an even greater importance.

VOLUNTARY SERVICE, VOLUNTARY WORKERS

1819. VOLUNTEER CENTRE. **Voluntary service co-ordinators in the health services 1978: a directory of posts.** Berkhamsted, Volunteer Centre, 1978, 82pp. £2.50

This edition of the directory lists voluntary service co-ordinator posts by area health authority and by post-graduate teaching hospitals in England and Wales, by health boards in Scotland and by health and social service boards in Northern Ireland. A list of posts in independent hospitals is also included. Supplementary indexes indicate the posts available by the name of the voluntary service co-ordinator; the name of the hospital; and by name of place in the voluntary service co-ordinator's postal address. An appendix includes three forms for notifying changes of post.

HOSPITAL SOCIAL WORK

See also Abstract Nos. 1817, 1887

1820. VOORDT, J. van de and MEHS, M. Krankenhaus-Sozialdienst. **[Hospital social work.]** *Fortschritte der Medizin*, München, 1978, July 20, vol. 96, no. 26/27, pp. 1345-1346, 1376.

The task of the hospital social worker is to deal with the social, economic and emotional problems of illness and to reduce to a minimum its harmful after-effects. This is done in collaboration with the patient himself, his relatives and other members of the hospital team. This paper outlines the problems involved and points out the differences between social work in the hospital and other types of social work. In general hospitals in the Netherlands there is one social worker for every 420 beds while the ideal would be one for every 70 beds: for long-stay hospitals the figures are 434 and 80 respectively.

1821. **Standards for hospital social services.** *Health and Social Work*, New York, 1978, May, vol. 3, no. 2, pp. 4-12.

These standards were developed jointly by the National Association of Social Workers and the American Hospital Association and are now being considered by the Joint Accreditation Commission for Hospitals. Each of the 11 standards is accompanied by an interpretive statement. The standards cover: (i) a written plan for providing social services; (ii) the need for administrative accountability and direction by a qualified social worker; (iii) the scope, objectives and organization of the programme must be clearly delineated; (iv) the functions; (v) the need for adequate

staffing; (vi) a staff development programme; (vii) a manual of policies and procedures; (viii) a written statement of personnel policies; (ix) the need for adequate documentation of activities; (x) a quality review; and (xi) the need for adequacy of budget, space, facilities and equipment.

1822. WILLIAMS, C. C. and others. **Social work and nursing in hospital settings: a study of interprofessional experiences.** *Social Work in Health Care*, New York, 1978, vol. 3, no. 3, pp. 311-322.

Social workers and nurses in hospitals often work together in interdisciplinary health care teams. Collaboration between the professions can be improved through a better understanding of each other's roles, skills and practice expectations. A study was carried out to investigate the types of interprofessional experiences that occur between hospital social workers and nurses during their training and clinical practice. It is only through the co-ordinated efforts of both professions that joint experiences can be provided in a planned attempt to increase understanding and improve teamwork and patient care.

1823. SOCIETY FOR HOSPITAL SOCIAL WORK DIRECTORS. **A reporting system for hospital social work.** Chicago, American Hospital Association, 1978, v, 26pp. $8.75

This booklet has been developed by the Society for Hospital Social Work Directors for use by social workers in health care institutions. It is a step-by-step guide to the collection and organization of statistical data which can be used to establish objectives and accountability and also for assessing the effectiveness of services in hospital social work departments. The reporting system is in five sections: a code sheet; an opening sheet; a transfer/closing sheet; a daily work sheet, and a monthly tally sheet. Although all five parts of the system function in concert to collect data, each part is discussed separately.

1824. SCHWARTZ, H. D. and KART, C. S. **Dominant issues in medical sociology.** Reading, Mass. and London, Addison-Wesley, 1978, xiv, 577pp. £9.75

This source book introduces the dominant issues in the field of medical sociology to the health care consumer. The 63 articles included are drawn from a wide number of published sources and cover both micro and macro issues. The book is divided into four main parts covering: the patient and his relationship to the practitioner; the role of hospital staff; the organization of the hospital; and the system of health care in America. Each of the 19 chapters is preceeded by an introduction that contains supplementary information, additional references, draws comparisons and parallels between selections and provides the historical and statistical background necessary for understanding the many implications of current trends and practices.

TERMINAL CARE

1825. BENTON, R. G. **Death and dying: principles and practices in patient care.** New York and London, Van Nostrand Reinhold, 1978, xii, 363pp. £10.50

This book presents the practical, theoretical, social and psychological aspects of death and dying. Chapter 1 and Chapter 2 examine the question of who has the right

or obligation to dispense with life-sustaining conditions. Chapter 3 focuses on the reactions of a person attempting to cope with finality. Chapter 4 presents situations in which death occurs and the sociological and cultural factors relevant to the death. Chapter 5 deals with changing perceptions of death through funerals, death rituals and religious influences. Chapter 6 explores how people react to disfigurements that are conceived as forerunners of death. Chapter 7 presents a series of case studies which aim to help people recognize the problems of death and dying. Chapter 8 considers the practical approaches of giving care and includes an information index, examples of forms to be completed and a checklist of religious rites. A glossary of terms is included.

1826. BLAKE, S. L. and others. **Dealing with death and dying: a nursing skill book.** 2nd edition. Jenkintown, Pa., Inter Med Communications, 1976, 192pp. £7.40

This book considers the practical problems of caring for the dying and suggests possible guidelines for nurses. It is divided into four sections: section 1 considers methods of dealing with the patient; section 2 considers ways of dealing with the family; section 3 considers nurses and their staff; and section 4 presents personal views. 'Skillcheck' questions, designed to help the reader develop his own skills, are provided after each section.

1827. EARLE, A. M., ARGONDIZZO, N. T. and KUTSCHER, A. H. **The nurse as caregiver for the terminal patient and his family.** New York, Columbia University Press, 1976, x, 255pp. $21.90

This book considers the role of nursing and the therapeutic relationship between the nurse, the terminal patient and the family. It is divided into three sections: part one considers living, dying and those who care; part two considers methods of coping with problems for professional staff; and part three discusses education in ageing and long-term care. An appendix considers death influence in clinical practice: a course outline for the nursing school curriculum.

1828. MCMULLIN, E. **Death and decision.** (AAAS Selected Symposium No. 18) Boulder, Colo., Westview Press for the American Association for the Advancement of Science, 1978, xii, 154pp. £9.70

The issues discussed are based on papers presented at the American Association for the Advancement of Science Annual National Meeting held at Denver, February 1977. Aspects presented include: definitions of death; the function of medicine; psychosocial factors in coping with dying; strategic relationships in dying; the right to die; euthanasia; the obligation to care; and demands for life and requests for death—the judicial dilemma.

1829. WAGNER-KOLB, D. Unser Umgang mit dem Sterben. **[Our dealings with death.]** *Deutsche Krankenpflege-Zeitschrift*, Stuttgart, 1978, June, vol. 31, no. 6, pp. 274-278.

The author, a consultant in obstetrics and gynaecology at a Hamburg hospital, discusses attitudes towards the dying patient from the doctor's viewpoint. The question as to how far efforts should be made to keep patients alive is illustrated by four

examples: only when there is a chance of survival should extreme measures be taken. The patient has a right to know if he is dying and should be helped to prepare himself. Doctors and nurses are given no training in caring for the dying patient. The state should provide special hospitals or homes for terminal patients, or at least special rooms in general hospitals with specially trained staff.

HOSPITAL CARE

See also Abstract Nos. 1761, 1772, 1783, 1815, 1859, 1863, 1880, 1881

1830. SANAZARO, P. J. and WORTH, R. M. **Concurrent quality assurance in hospital care: report of a study by private initiative in PSRO.** *New England Journal of Medicine*, Boston, 1978, May 25, vol. 298, no. 21, pp. 1171-1177.

To test the feasibility and effects of incorporating concurrent quality assurance (CQA) into the current use reviews required by Professional Standards Review Organizations (PSROs), adherence to essential criteria of medical care and attainment of expected immediate outcomes was monitored prospectively in 5,604 cases of seven conditions in 24 experimental and 26 control hospitals in five PSRO areas. CQA was not consistently associated with improved documentation in records, but was associated with slightly better adherence to treatment criteria in all five PSRO areas. Adherence to pooled documentation or treatment criteria was unrelated to outcomes. However, failure to adhere to disease-specific scientifically validated treatment criteria was associated with unsatisfactory outcomes in bacterial pneumonia and acute myocardial infarction. CQA was professionally acceptable, technically feasible and compatible with PSRO reviews. Given adequate physician support, CQA can produce slightly greater adherence to treatment criteria. If the criteria are valid, adherence may lead to improved immediate outcomes in some diseases.

1831. DOUGHTY, D. B. and MASH, N. J. **Nursing audit.** Philadelphia, F. A. Davis, 1972, ix, 225pp. £6.50

This book presents methods and guidelines for carrying out nursing audit. The background and basis of the methods are discussed together with the need to select and construct quality criteria. Examples of forms and layouts for use during the audit are included. Sample sets of criteria covering a number of the diagnoses and reflecting many of the problems frequently encountered are included in order to serve as a starting point for criteria development.

1832. DUCKETT, S. J. and KRISTOFFERSON, S. M. **An index of hospital performance.** *Medical Care*, Philadelphia, 1978, May, vol. 16, no. 5, pp. 400-407.

A simple index for computing relative hospital performance is described. An analysis of 33 short-stay general hospitals in New South Wales was used to develop the index which is based on patterns of admission for each hospital, adjusting the hospital's crude death rate for the age distribution of patients treated and variations in the severity of their diagnoses. The index is relatively simply to calculate, but is nevertheless a valid indicator of hospital performance.

1833. BRYE, P. E. and READING, R. J. **EMS or HSA: which program model influences health delivery more?** *Hospitals*, Chicago, 1978, June 1, vol. 52, no. 11, pp. 55-57.

In the past five years, two United States federal laws that have been enacted show there is continuing confusion in the federal government's attempts to change the health care delivery system. The Emergency Medical Services Systems Act of 1973 as amended in 1976 (EMS) and the National Health Planning and Resources Development Act of 1974 (HSA) differ radically in the concept of operation, agency structure, roles of consumers and health care professionals, method of funding, and control by the federal government. Both the government and providers should study the differing impact of the programmes in order to determine which approach can more effectively change health care delivery.

1834. LIPP, M. R. **Respectful treatment: the human side of medical care.** Hagerstown, M.D., and London, Harper & Row, 1977, xii, 232pp. £8.65

This book focuses upon approaches to such problems as the patient who refuses care, those with chronic pain, patients in a state of confusion due to age, alcoholism or drugs, the emotional aspects of major disease categories, and psychological problems in intensive care units. There is information on psychiatric diagnosis—its use and misuse, the effect of the hospital environment on both patient and doctor, how the doctor can most effectively cope with and direct his own motivations and reactions, as well as a discussion of effective drugs and those contraindicated.

DISCHARGE OF PATIENTS

See Abstract Nos. 1776, 1888

HOME CARE, AFTER-CARE

See also Abstract Nos. 1841, 1866

1835. TOLKOFF-RUBIN, N. E. and others. **Co-ordinated home care: the Massachusetts General Hospital experience.** *Medical Care*, Philadelphia, 1978, June, vol. 16, no. 6, pp. 453-464.

The Massachusetts General Hospital Co-ordinated Home Care Scheme administered by the Boston Visiting Nurse Association, has demonstrated that home care can be a viable, economically feasible alternative to institutionalization for carefully selected patients when the appropriate medical and social needs can be met. Three major groups of patients have been effectively cared for: (i) patients with multi-system chronic illness; (ii) patients with terminal malignancies; and (iii) patients with catastrophic neurological disease. The organization of the Co-ordinated Home Care Scheme, the criteria for patient selection, and the issue of funding are reviewed. The impact of this scheme is examined in terms of its potential for better use of the facilities of the Massachusetts General Hospital, as well as the more appropriate co-ordination and use of existing health care resources in the community.

SPECIAL DEPARTMENTS

OPERATING SUITES

See also Abstract Nos. 1784, 1802

1836. JORIO, A. L'unità operatoria modulare (UOM). **[The modular operating unit.]** *Tecnica Ospedaliera*, Milano, 1978, June, vol. 8, no. 6, pp. 21-39.

This is an account of a research project set up with the purpose of rigorously applying a metaprojection method to the field of hospital design, to encourage rationalization of design methods, and to define a complete cognitive basis to take account of the needs of patients and staff. The procedures employed are summarized in a diagram and the 20 phases of research and their results are also presented. The eight figures include a matrix showing the sequence of operations carried out by each user in the theatre unit. The people involved in the project concentrated on analyzing and making explicit the functional aspects which influence the 'type' of space rather than on showing what the physical characteristics of the building should be.

1837. CHÜDEN, H. G. Video-Technik in der Klinik: Spielerei oder Fortschritt? **[Video recording in the hospital: a gimmick or an advance?]** *Fortschritte der Medizin*, München, 1978, July 20, vol. 96, no. 26/27, pp. 1377-1379.

Audio-visual aids are shown to be a necessity for postgraduate medical education. Colour television and video tapes play an important role in this field and this paper sets out the possibilities for their use. Colour television is quite successful for ear, nose and throat work. The camera can be used in microsurgery (e.g. in tympanoplasty) connected to the microscope so that the picture can be controlled, corrected and explained by the tutor. The principal recording systems are briefly described together with a mobile video-television apparatus which has lecture-room connections for picture and sound and a built-in loudspeaker.

ANAESTHESIA

See also Abstract No. 1883

1838. RUNNELLS, G. **Guidelines to assist hospitals in the use of ethylene oxide.** *Hospitals*, Chicago, 1978, May 1, vol. 52, no. 9, pp. 119-122.

A survey undertaken by the American Society of Hospital Central Service Personnel and a study by the National Institute of Occupational Safety and Health form the background for the guidelines presented in this paper, together with explanatory notes.

PHARMACY

1839. MILLER, B. R. **Hospital pharmacy in Australia.** *American Journal of Hospital Pharmacy*, Washington, D.C., 1978, June, vol. 35, no. 6, pp. 673-677.

Hospital pharmacy practice in Australia is reviewed. Topics covered include

pharmaceutical education, drug distribution, purchasing of pharmaceuticals, and hospital pharmacy staffing and services. Australia has a national health insurance system which directly affects both community and hospital pharmacy practice. Practitioners have tried to introduce innovations such as intravenous admixture services, unit drug dose distribution systems and drug information services although limitations imposed by restricted government funds have inhibited the introduction of innovations. The Society of Hospital Pharmacists of Australia offers a continuing education correspondence course which leads to the granting of a Fellowship in Hospital Pharmacy. Future developments in hospital pharmacy practice are discussed.

1840. GINNOW, W. K. and KING, C. M. **Revision and reorganization of a hospital pharmacy policy and procedure manual.** *American Journal of Hospital Pharmacy*, Washington, D.C., 1978, June, vol. 35, no. 6, pp. 698-704.

The development of a hospital pharmacy policy and procedure manual both as an administrative tool and to provide employees with an immediate source of current and reliable operating information is discussed. Key factors in the design of the manual were flexibility and the capability of being easily revised. Decisions were made on table of contents, referencing system, the physical specifications for the manual, and editorial policies. The concept of a procedure specialist to co-ordinate all activities regarding the manual was examined. It is recommended that all staff members participate in the development and revision of policies and procedures.

1841. ROSEN, C. E. and HOLMES, S. **Pharmacist's impact on chronic psychiatric outpatients in community mental health.** *American Journal of Hospital Pharmacy*, Washington, D.C., 1978, June, vol. 35, no. 6, pp. 704-710.

The impact of a specially trained pharmacist upon the treatment of chronic psychiatric out-patients maintained within their communities was studied. The quantity and costs of the services provided were assessed as well as patient satisfaction and well-being. The pharmacist monitored the drugs of about 200 chronic psychiatric patients each month. The cost of a pharmacist providing a medication monitoring service was 40 per cent of the cost of providing that service by a psychiatrist. The pharmacist's patients were found to be functioning in the community as well as or better than other patients and their reported satisfaction with treatment was at least that of other chronic psychiatric patients sampled. The results indicate that the psychiatric pharmacist successfully monitored stabilized psychiatric patients within their communities.

1842. RUGER, J. R. and DURGIN, J. M. **Drug information: an overview and prospect for the future.** *Drug Intelligence and Clinical Pharmacy*, Hamilton, Ill., 1978, April, vol. 12, no. 4, pp. 231-239.

The need and demand for improved drug reaction reporting, literature access, control and dissemination, and student-literature exposure has been evident for many years. Drug information distribution is a function of the pharmacy which is carried out by the communication of information, improving retrieval systems and offering individualized services. The drug information specialist must be clinically-oriented and overcome barriers to information transmission. He is also concerned with bibliographic control and systems improvement and design. He requires specialized education obtainable from schools of graduate pharmacy and of library and information science.

1843. WOODHOUSE, L. and MCLEAN, W. M. **Clinical significance of drug interactions detected by pharmacist monitoring.** *Canadian Journal of Hospital Pharmacy*, Saskatoon, 1978, May/June, vol. 31, no. 3, pp. 81-84.

A two-month study at Ottawa General Hospital investigated the significance of drug-drug interactions detected by pharmacist monitoring of medical profiles of patients on a medical teaching unit. Following an initial profile study of 139 patients on three wards, a second study was carried out in which the course of each patient on one ward with a suspected interaction was followed and the various parameters determined for each interaction were maintained. Of the 79 possible interactions detected, nine were prevented, 19 were desired, 13 were not significant due to dosage times, two were not significant due to route of administration, seven were not significant due to the drugs not being given, and 29 were found to be clinically insignificant. It was concluded that drug interactions do not play as large a part in causing drug adverse reactions as has been thought and that more emphasis should be placed on other aspects of drug monitoring.

1844. PUCKETT, W. H., BENNETT, D. L. and BREINING, J. G. **ABC analysis helps to determine which drugs to bid purchase.** *Hospitals*, Chicago, 1978, June 1, vol. 52, no. 11, pp. 91-94.

The advantages of purchasing by tender to both buyer and supplier are described and the ABC classification of inventory is explained. Use of the ABC system and purchasing by tender by the department of pharmacy services, Grant Hospital, Columbus, Ohio, is described. Although the tender process has its costs (mainly in professional time), purchasing by tender can be a valuable mechanism by which the pharmacist can reduce the acquisition cost of pharmaceuticals. The ABC inventory classification can be used as a systematic method of analyzing the inventory for potential tender items. The result will be maximization of costs saved for the time invested.

1845. GOUSSE, W. L. **Computer system for unit dose drug distribution.** *American Journal of Hospital Pharmacy*, Washington, D.C., 1978, June, vol. 35, no. 6, pp. 711-714.

A computerized unit drug dose distribution system forming part of an on-line hospital information system at Maine Medical Center, Portland, ME., is described. Differences between manual and computerized pharmacy distribution, and the advantages and disadvantages of the automated system are discussed. The system appears to improve the efficiency of the pharmacy together with its accuracy, control of drugs and capabilities for patient monitoring and drug use review. If mechanical failure occurs, back-up procedures keep the distribution system operational. The computer system is believed to decrease the time spent by pharmacists on routine distribution tasks, leaving time for other necessary pharmacy work.

1846. DANGOUMAU. Le médicament à l'hôpital: la prescription. Deuxième partie. **[Medicines in hospital: prescriptions. Part two.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1978, June/July, nos. 393/394, pp. 35-44; summaries in English, German, Italian and Spanish, pp. 43-44.

Within the context of the development of a prescriptions policy in the hospital, the

author first examines the problems of monitoring drug therapy and drug safety, including the detection and prevention of undesirable side-effects and drug alert schemes, and makes detailed recommendations for improvements in these areas. He then considers at length the problems of keeping abreast of new developments; doctors are bombarded with a mass of information but this is not always objective or rigorously scientific. He recommends that bulletins or letters on advances in drugs and therapeutics be circulated at regular intervals and that seminars in clinical pharmacology be held for hospital doctors and pharmacists. Changes in structures such as the establishment of a medicines committee, the appointment of a clinical pharmacologist, and the re-organization of the hospital pharmacy are relatively easy to achieve; what is more difficult but equally important is to change attitudes and create a general awareness of the real problems.

1847. DANGOUMAU, A. J. Le médicament à l'hôpital. Éléments d'une politique de prescription. **[Drugs in hospital. Features of a prescription policy.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1978, May, No. 392, pp. 41-48, 51-52.

No explicit prescription policy exists in the majority of French hospitals today. The author examines the problem of the prescription under five headings: (i) the prescriber; (ii) the choice of medicinal products; (iii) the value of these products; (iv) monitoring the effects of these products; and (v) drug safety. In a critique of the present system, he suggests that each hospital should have a restrictive list of medicinal products in current use, that controlled trials on new products be carried out in hospitals, that the French system of expert reports on new drugs be revised, and that steps be taken to ensure that the hospital incurs no unnecessary expenditure when reports of this kind are being prepared. He proposes that ethical committees might be established to ensure that the interests of the patient are respected when new drugs are being tested.

1848. JAMES, R. M. and others. **A computerized scheme for the preparation of parenteral nutrition regimes.** *Medical Informatics*, London, 1978, June, vol. 3, no. 2, pp. 77-86.

A computerized system to help clinicians design intravenous feeding regimes using proprietary parenteral nutrition solutions is described. The Nutrient Requirements Program uses patient data and the result of blood and fluid excretion analyses to calculate nutritional requirements for 24 hours. The Bottle Selection Program selects an intravenous bottle regime to suit patient requirements from a standard set of four groups of solutions. The scheme in operation at the Lancaster Royal Infirmary has been well accepted by clinical staff and financial savings have been noted by the pharmacy.

LABORATORIES

1849. HENREY, J. B. and GIEGEL, J. L. **Quality control in laboratory medicine: transactions of the first Inter-American Symposium, Key Biscayne, Florida, April 8-9, 1976.** New York, Masson, 1977, xii, 237pp. £20.00

The transactions of the first Inter-American Symposium on Quality Control sponsored by the American Hospital Supply Corporation are presented. The variety

of papers reveals that the practice of quality control in laboratory medicine is increasing in complexity and is more interdisciplinary. Topics considered include the problems of enzyme management common to both coagulation and chemistry; and the progress being made on national and international levels.

1850. CADA, R. L. and WEST, D. K. **Quality assurance practice in rural and urban hospital clinical laboratories.** *Health Laboratory Science*, Washington, 1978, April, vol. 15, no. 2, pp. 112-120.

This survey examined quality assurance methods in matched pairs of rural and urban hospital clinical laboratories. No major differences were discovered between the rural-urban pairs regarding staff qualifications, laboratory management, internal quality control methods and proficiency testing enrollment. Deficiencies observed were either generic or size-related. Most laboratories were organized by doctors; almost half spent five or less hours per week in the laboratory. All respondents employed at least one individual professionally qualified at the 'technologist' level. All respondents insisted that they employed a laboratory management system for quality performance although 20 per cent did not give details. Internal quality control practice varied widely. Many who replied recognized shortcomings related to volume and budget and requested specific training courses for technical staff. At least 20 per cent of the laboratories were not enrolled in any recognized proficiency testing scheme, which is an integral part of the total quality assurance process.

1851. THE PUBLIC HEALTH LABORATORY SERVICE SUB-COMMITTEE ON LABORATORY AUTOCLAVES. **Autoclaving practice in microbiology laboratories: report of a survey.** *Journal of Clinical Pathology*, London, 1978, May, vol. 31, no. 5, pp. 418-422.

As part of the general concern over safety standards, 27 laboratories in the Public Health Laboratory Service (PHLS) were encouraged to obtain thermometric equipment to monitor the performance of their autoclaves. This provided an opportunity to discover whether, when the autoclaves were operated in accordance with the normal practices in use in those laboratories at the time of acquisition of the equipment, sterilizing performance was satisfactory and cooling of the loads was adequate to allow the autoclaves to be opened safely. The results of the survey revealed that sterilizing performance was unsatisfactory on 10 out of 62 occasions, and cooling was inadequate on 52 out of 62 occasions. A summary of advisory notes on the safe and efficient use of laboratory autoclaves is included with six references.

1852. HARTREE, E. and BOOTH, V. **Safety in biological laboratories.** (Biochemical Society Special Publication No. 5) London, Biochemical Society, 1977, xii, 68pp. £1.00

This booklet has been designed to inform life science laboratory staff of the need to take all appropriate precautions to avoid risks of injury and accident. The seven chapters are each written by different authors and consider different topics: precautions for all laboratory workers; electrical hazards, fire and explosion; the role of the safety officer; the animal house; microbiological hazards; carcinogens, mutagens and teratogens; and radiation hazards. The emphasis is on safety rather than on danger, on the avoidance of risks and the need for safety consciousness for the benefit of officers as well as the worker's own person.

RADIOLOGY

1853. BUREAU, J. Le rayonnement ultra-violet germicide et son action de décontamination: les appareils à rayonnement ultra-violet germicide. **[The use of ultra-violet [germicide] rays in decontamination: the equipment.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1978, June/July, nos. 393/394, pp. 65-72; summaries in English, German, Italian and Spanish, p. 72.

This is a guide to: (i) modern theories on electromagnetic radiation; (ii) the different categories of ultra-violet radiation tubes; (iii) the units of measurement employed; (iv) the various ways in which the equipment can be installed and used; (v) the methods used to calculate the amount of apparatus required as a function of the volume to be decontaminated; (vi) new apparatus, including the PL3,000; (vii) the construction of the apparatus; and (viii) maintenance. In the author's view, the most important point to bear in mind is that a badly maintained UV generator which diffuses a bluish light will have no germicidal power and may not just be ineffective but may well be dangerous. He recommends that all surfaces in premises decontaminated by UV radiation be carefully and regularly cleaned with an efficient detergent.

DIAGNOSTIC X-RAY DEPARTMENT

1854. WOBBE, G. and KAMINSKY, G. Datenerfassung in der Röntgenabteilung eines Krankenhauses mit Hilfe von messenden Zeitstudien und Multimomentaufnahmen. **[Collecting data in the X-ray department of a hospital with the help of measuring time-studies and multi-moment exposures.]** *Krankenhaus-Umschau*, Kulmbach, 1978, June, vol. 47, no. 6, pp. 443-446.

This study of the X-ray department of a 300-bed hospital which carried out 57,493 X-ray examinations in 1976, had two objectives: (i) to obtain data on the time taken for typical X-ray procedures; and (ii) to obtain data on the use of staff-time and of equipment. The results are set out in a series of tables. Data on (i) are shown separately for in- and out-patients and give (in minutes) the times the clerk, the radiographer and the radiologist take for selected examinations. The data on (ii) are obtained from multi-moment frequency time procedures and give a breakdown, in percentages, of the proportion of time spent by clerks, radiographers, radiologists and nurses on different activities as well as the percentage of unproductive time. A study was also made of the degree to which various items of X-ray equipment were used, expressed as a percentage.

RADIOISOTOPE DEPARTMENT

1855. CONSTANT, R. L'Institut National des Radioelements: le point de son évolution à fin 1977. **[National Radioisotope Institute: its development to the end of 1977.]** *Hôpital Belge*, Bruxelles, 1978, May/June, no. 133, pp. 19-26.

The Belgian National Radioisotope Institute was established in 1970 and took over the work of the radioisotope department in the Nuclear Energy Research Centre at

Mol. The aim of this re-organization was to group all activity relating to radioisotopes in one centre at Fleurus near Charleroi. By May of this year the units which had moved to Fleurus included the administrative staff, the industrial applications unit, the labelled organic molecule unit which provides a radio-active labelling service for medicine, industry, and the universities, a radio-immunology unit, and cells for the production of radioisotopes which have a high level of radioactivity, for example, iridium-192 and xenon-133, mainly for medical use. Other buildings under construction are for the development of the Mediris programme, concerned with the application of gamma rays, radiochemistry, and industrial applications such as polymerization, plastic wood, etc. Some services are provided free, while others such as radio-immunological determination kits are marketed throughout the world. The description is accompanied by eight photographs, a plan of the site, and three graphs which show the growth in sales and receipts between 1972 and 1977.

REHABILITATION

See also Abstract Nos. 1797, 1876, 1889

1856. ADE, G. and MONTETON, R. von. Fortbildungsseminar für die rehabilitationskrankenpflege. **[Further training seminar for rehabilitation nursing.]** *Deutsche Krankenpflege-Zeitschrift*, Stuttgart, 1978, June, vol. 31, no. 6, pp. 283-286.

This is a report on the first in-service post-basic training course in rehabilitation nursing held at the Karlsbad-Langensteinbach Rehabilitation Hospital from April to July 1977. Five nurses took part and over the period there were 174 hours of theoretical instruction in: basic medical aspects; treatment; rehabilitation psychology; and special nursing. Practical training, in which students had to report on patients allocated to them, included spending a whole day in a wheelchair. It is concluded that on the whole the course was useful and future courses will have more participants.

1857. GIANOTTI, N. and CORNA, L. D. Considerazioni di natura economica sulla riabilitazione in Italia. **[Consideration of the economics of rehabilitation in Italy.]** *Tecnica & Metodologia Economale*, Pisa, 1978, March/April, vol. 17, no. 2, pp. 73-74, 76-78.

The rehabilitation of the victims of accidents, injury, or illness is worthwhile from a purely economic point of view. Using American data, the author shows that in cases of hemiplegia due to cerebrovascular accidents there is a net economic benefit to society if these patients can be helped to become independent. Moreover, a proper rehabilitation programme would encourage the development of new devices for the disabled, which might then be marketed abroad as well as in Italy.

1858. GLOMBIG, E. Rehabilitation—Bilanz seit 1969 und Ausblick. **[Rehabilitation—results since 1969 and prospects for the future.]** *Rehabilitation*, Stuttgart, 1978, Aug., vol. 17, no. 3, pp. 127-132.

The author presents a review of rehabilitation legislation which has been promulgated in Western Germany since 1969. This shows that for the first time attempts have been

made to create a uniform policy for the disabled. The aim has been to eliminate differences in the treatment of the disabled which has varied according to the origin of the disability. It is however emphasized that further reform is necessary: this includes more standardization of rehabilitation services; reform of the system of benefits; improvement of social security for those needing care; and the guarantee of a regular income for those disabled from birth or childhood.

DEPARTMENTS FOR SPECIAL THERAPY

See also Abstract No. 1884

1859. WESTERMEYER, J., DOHENY, S. and STONE, B. **An assessment of hospital care for the alcoholic patient.** *Alcoholism: Clinical and Experimental Research*, New York, 1978, Jan., vol. 2, no. 1, pp. 53-57.

Current medical practice regarding diagnosis, treatment and referral of alcohol- and drug-dependent patients was assessed in a university hospital. The findings indicate that the majority of physicians and nurses at the hospital did not: (i) take adequate alcohol and drug use histories; (ii) identify chemical dependency as a medical problem even when they knew dependency was present; and (iii) involve themselves in treatment or treatment recommendations even when the problem was identified. These attitudes among physicians and nurses lag far behind accepted medical practice and are often detrimental for patients who need to be reassessed by health workers. Physicians and nurses need to acquire skill in taking alcohol and drug histories, in assessing problematic use of such chemicals, and in referring such patients for treatment. Interested clinicians should have the opportunity to obtain training in the treatment of alcohol- and drug-dependent patients.

INTENSIVE CARE UNITS

See also Abstract No. 1875

1860. WELTER, R. and GESSNER, U. Benutzer-orientierte Entwicklung einer Gerätesäule für die Intensivpflegestation. **[User-oriented development of an instrument column for the intensive-care ward.]** *Medizinal-Markt: Acta Medicotechnica*, München, 1978, July, vol. 26, no. 7, pp. 221-223.

In a four-bedded intensive care ward the average number of bedside instruments per patient was 6.8, with a range of 5.5 to 10.7 according to the severity of the illness and the dependency of the patient. With the aim of having the various instruments placed in the most suitable positions in relation to each other and for the convenience of patients and staff, scale models were prepared and discussed by doctors and nurses. Finally a mobile instrument panel, of metal construction, was designed. Instruments were connected from above thus leaving walls free. The panel can be assembled outside the ward, thus reducing disturbance to patients, and can be taken out of the ward for cleaning and disinfection. The paper is illustrated with photographs and diagrams.

SPECIAL HOSPITALS AND UNITS

OUT-PATIENT

See also Abstract No. 1866

1861. LASDON, G. S., editor. **Improving ambulatory health-care delivery: multidisciplinary applications.** Lexington, Mass., Lexington Books, 1977, ix, 207pp. £12.00

This book reflects the change in health services research from an academic application of theory to the objective of finding practical solutions for decision-making. The proceedings are given of the Conference on Improving Ambulatory Health Care Delivery, sponsored by the United Engineering Foundation, Engineering Foundation Conferences, held in Henniker, N.H., on 27 June to 2 July 1976. The papers are in six parts which reveal the multidisciplinary nature of the conference. Part one considers manpower and technology alternatives to increase availability; part two considers quality assessment; part three presents cost analysis; part four considers regional planning; part five considers patient-oriented care; and part six outlines the administrator's viewpoint. Biographical details are included about the contributors and the editor.

1862. ZILM, F. **Ambulatory care survey paves way to the future.** *Hospitals*, Chicago, 1978, June 1, vol. 52, no. 11, pp. 79-80, 82-83.

The University of Utah collected data from 3,000 patient visits to its ambulatory care clinics to determine how it should build a new facility aimed at the 1985 population and service levels. The key to the survey was a specially designed patient encounter form, which could be completed by the clinic's clerical and nursing staff with a minimum of effort. The procedure for collecting the data is outlined and the data collected are summarized in two tables. As a result of the survey, a 12-examination room module unit was established as the best size to meet institutional needs. Each module is organized to provide subdivision into six examination rooms with shared support services, allowing smaller clinics to operate simultaneously in a module. Each module is also provided with teaching/conference space and patient holding and service areas.

1863. STEINWACHS, D. M. and YAFFE, R. **Assessing the timeliness of ambulatory medical care.** *American Journal of Public Health*, Washington, D.C., 1978, June, vol. 68, no. 6, pp. 547-556.

The extent to which individuals receive necessary and timely care is one dimension of the process of care that has received little attention. Timely care can be considered as the interaction between patient-care and seeking behaviour and system accessibility, both of which are expected to influence the effectiveness of medical care. This study examines the assessment of the timeliness of care received in the department of medicine of a prepaid scheme. Provider judgements were found to be significantly related to the provider's perception of problem severity and to the patient's prognosis. Analyses of patient-reported problem status one week later were also found to be related to the timeliness of care. Implications of timeliness assessments for monitoring and improving access and care-seeking behaviour are discussed.

1864. NICHTERN, S. **The walk-in clinic.** *Journal of Adolescence*, London, 1978, March, vol. 1, no. 1, pp. 55-60.

The 'walk-in' clinic is suggested as a system of care for adolescents because of their need for quickly available, short-term treatment. Adolescents are often pre-occupied with their physical and mental state and may have an unsettled relationship with their families. Three separate types of 'walk-in' clinics and the problems encountered are described. These are: (i) the clinic in the emergency admitting department of a general psychiatric hospital, where problems are acute; (ii) a store-front clinic; and (iii) an associated emergency shelter to help 'runaways', drug addicts and those with educational, sexual and social problems. The observation of these clinics emphasized the importance of immediate intervention and confirmed the view that many adolescent problems are the product of family and social disorder.

CASUALTY AND ACCIDENT

See Abstract Nos. 1747, 1770, 1877, 1890

DAY HOSPITALS

1865. WEISSERT, W. G. **Costs of adult day care: a comparison to nursing homes.** *Inquiry*, Chicago, 1978, March, vol. 15, no. 1, pp. 10-19.

Mounting demand and escalating costs have led to critical assessments of traditional institutional long-stay care. One possible solution to the problems involved is day care. Day care has been slow to develop in the United States and at the time of the study reported here (July 1974) only 18 centres were known to the experts. Ten of these centres were selected on a non-random quota basis to represent a broad mix of organizational characteristics. During three- to four-day visits to each centre, staffing, staff time allocation on a functional task basis, participant health status characteristics, income, expenditure and cost data were collected for a sample period of one-quarter year. The results of the survey are presented in six tables and costs are compared with those of nursing homes. Although day care is slightly more costly per day, it is only provided intermittently (2.5 to four days a week); even when the non-programme expenses of living at home are included, this represents a saving of 12 to 35 per cent compared with the cost of nursing home care.

CHEST

See Abstract No. 1811

CHILDREN

See also Abstract No. 1864

1866. STEIN, R. E. K. **Pediatric home care: an ambulatory 'special care unit'.** *Journal of Pediatrics*, St. Louis, 1978, March, vol. 92, no. 3, pp. 495-499.

The paediatric home care programme at the Bronx Municipal Hospital Center,

New York, has operated as an ambulatory special care unit since 1970. The programme provides care for seriously or chronically ill children, who would not be adequately served by traditional ambulatory services because of either the severity and complexity of their medical problems or the inability of their families to use such services. Monitoring of patients, delivery of direct services, health education and co-ordination of services are provided by an interdisciplinary team. The work of the team is reviewed and a typical case report presented. This form of special ambulatory care appears to offer advantages to patients who are at risk in existing ambulatory schemes and is an alternative to in-patient care, against which it shows a considerable cost saving.

1867. POWAZEK, M. and others. **Emotional reactions of children to isolation in a cancer hospital.** *Journal of Pediatrics*, St. Louis, 1978, May, vol. 92, no. 5, pp. 834-837.

Emotional reactions of children with cancer and their mothers were evaluated during standard isolation and during isolation with communication through a glass partition and an intercom. Neither the patients' nor the mothers' anxiety differed according to the type of isolation, but about half the mothers had an appreciable amount of depression and patient depression increased with age. Parents with children under six years of age were more aware of the benefits of the glass partition type of isolation. The overall high level of anxiety and depression observed indicated the urgent need of support for families in dealing with the psychological aspects of serious disease.

1868. TOURNIER, R. La santé de l'enfant: aspects et perspectives de la pédiatrie hospitalière. **[Child health: aspects and perspectives of hospital paediatrics.]** *Gestions Hospitalières*, Mantes, 1978, May, no. 176, pp. 409-414.

The first of these two extracts from a thesis on child health relates to the prevention of neonatal infection, and some aspects of asepsis, disinfection, and isolation are briefly reviewed. In the second extract, the problems of forecasting requirements in hospital paediatric departments are discussed. The number of beds needed is not only a function of local population or accessibility, but it also reflects the reputation of a particular doctor or unit, and whether a child is brought for treatment to a paediatrician rather than to a specialist in urology or orthopaedics. This last point leads on to a general discussion of specialization among doctors and the development of new 'super'-specialties.

GERIATRICS AND LONG-STAY

See also Abstract Nos. 1814, 1835, 1865

1869. Statistique annuelle des hospices et maisons de retraite publics en 1976. **[Annual statistics of hospices and public homes for the aged in 1976 in France. Provisional results.]** *Santé Securité Sociale, Statistiques et Commentaires*, Paris, 1978, March/April, no. 2, pp. 5-14.

In a series of three tables, in which the data are broken down by *Département* and Region, and six maps, statistics relating to the number of public almshouses and old people's homes in France in 1976 are presented. The total number of homes (1,112) and beds (97,516) have not changed significantly since 1975, but some progress has been

made in reducing the number of large wards. The percentage of beds occupied ranged from under 91 per cent in Burgundy, the Franche Comté, the Pyrenees, Provence and the Côte d'Azur to over 97 per cent in Brittany, Lower Normandy, Poitou and Charentes, and Aquitaine.

1870. MANCHESTER UNIVERSITY. DEPARTMENT OF COMMUNITY MEDICINE. UNIT FOR CONTINUING EDUCATION. **The psychogeriatric problem: is there a solution?** Proceedings of a seminar, November 3rd-4th 1977, Holly Royde College, Manchester. University of Manchester, 1978, 26pp.

This workshop was designed to meet a demand for multidisciplinary consideration of the issues relevant to the elderly mentally ill. The papers presented considered: the identification of the problem; the development of a psychogeriatric service; psychogeriatrics and crisis intervention; nursing aspects; the view of the Department of Health and Social Security; psychogeriatrics and the social services; and the role of the community physician. Reports were submitted from four groups of participants who considered four aspects of geriatric care: (i) is the care of the underprivileged a priority; (ii) the primary care team—does it exist and is it necessary for care of the elderly mentally ill; (iii) the role of the district general hospital; and (iv) crisis intervention.

1871. WOOD, P. H. N. **Symposium: the young chronic sick.** *Journal of the Royal Society of Medicine*, London, 1978, June, vol. 71, no. 6, pp. 437-453.

This symposium on the young chronic sick includes four papers on: (i) the size of the problem and the causes of chronic sickness in the young; (ii) general management of the young chronic sick; (iii) the planning and running of a young chronic sick unit; and (iv) voluntary aspects of long-term care. The first paper investigates the statistical sources for the numbers and causes of disabling conditions found in those under retirement age and discusses their distribution among various age groups. The second paper discusses the problems faced by the disabled, the services provided for them, the type of accommodation required, and the difficulties encountered in the education of disabled children. The third paper describes the Lonsdale Unit for the young disabled at Whitehaven Hospital, Cumbria. The final article describes the part played by the Cheshire Homes in the care of the chronic sick.

CANCER

See Abstract Nos. 1797, 1867

NEUROLOGY AND NEUROSURGERY

1872. BROCKLEHURST, J. C. and others. **Why admit stroke patients to hospital?** *Age and Ageing*, London, 1978, May, vol. 7, no. 2, pp. 100-108.

Of 135 patients with a recent hemiparesis who were examined, two thirds were admitted to hospital in the first two weeks. Features favouring admission were urgency in seeking medical help, rapid achievement of full disability, high level of disability

and disturbed consciousness at onset. However, many very disabled patients were not admitted and equally relevant factors favouring admission were social: living alone or with spouse, rather than with child or daughter-in-law; chief carer being male, over 70 and of social classes 3, 4 or 5. Equal numbers of patients aged over 65 were admitted to medical and geriatric wards in the first two weeks, the main difference being that those presenting more urgency were admitted to medical wards, and those with left hemiplegia or with a history of heart disease were more likely to be admitted to geriatric wards. Few complex investigations were carried out. Since the overall reasons for admission were principally the need for nursing care in association with social problems at home, increased domiciliary support and early hospital care might well diminish further the number of stroke patients admitted to hospital.

CARDIOLOGY

1873. PICART, N. Un exemple des réalisations récentes: nouvelle unité coronaire de l'Hôpital Civil de Charleroi—mai 1978. **[An example of recent developments: new coronary unit at Charleroi Civil Hospital, May 1978.]** *Hôpital Belge*, Bruxelles, 1978, May/June, no. 133, pp. 15-17.

A new six-bed cardiac unit which replaces the original four-bed unit at Charleroi Civil Hospital is described. Its special features include four movable pressure monitors. Eight patients can be monitored at one time: six in the coronary unit itself and two others by telemetry. A computer-operated cardiac arrhythmia detector which alerts the nurse on duty to any changes in the ECG traces can also produce graphs showing the course of cardiac frequency and arterial tension over time. The central monitoring post includes two oscilloscopes with four ECG traces displayed on each, two telemetry receivers, the ECG recorder, the ambient illumination control panel, the alarm module, and the computer controls. The description includes two photographs.

1874. WOOD, J. B. and others. **Myocardial infarctions in the catchment area of the Hereford hospitals: a community study.** *Public Health*, London, 1978, May, vol. 92, no. 3, pp. 113-120.

All known myocardial infarctions in the catchment area of the Hereford hospitals were recorded from March 1974 to February 1975. A total of 533 myocardial infarctions were recorded from 516 patients, consisting of 286 notifications from hospitals and general practitioners, 124 cases diagnosed at post mortem and a further 123 cases discovered through death certificates. Details are presented in six tables and discussed. The discussion is particularly concerned with the implications for the four-bed coronary care unit to be opened in the area.

1875. POZEN, M. W. and others. **Ambulance utilization by patients with acute myocardial infarction.** *American Journal of Public Health*, Washington, D.C., 1978, June, vol. 68, no. 6, pp. 568-572.

Fifty five per cent of patients with myocardial infarction on Cape Cod during a three-month period reached the hospital by ambulance. The 45 per cent not using ambulances were compared with the users to identify a sub-population to which public health schemes might be directed in order to increase appropriate use of cardiac

ambulances. Univariate analyses revealed that a distance of more than 10 miles from the hospital, and a prior history of myocardial infarction distinguished ambulance users from non-users. Demographic/economic status, delay in seeking care, presenting symptoms, Killip class, and in-hospital mortality rates were not significantly different. Discriminant analysis identified four variables in order of importance: distance from the hospital; past history of myocardial infarction; symptoms of fainting; and negative history of hypertension. These variables classified 72 per cent of the population with respect to ambulance use.

ORTHOPAEDICS

1876. NEWMAN, G. **Otara Spinal unit posed design problems.** *New Zealand Hospital*, Wellington, 1978, April, vol. 30, no. 3, pp. 15, 17.

The Otara Spinal Unit was provided to centralize specialized rehabilitation services for patients with spinal injury. The type of heating, ease of access and space for manoeuvre were among the aspects to be considered in the design. The site itself was expansive and in order to provide ready access, single-storey buildings were chosen. The consequent distance from wards to treatment areas has proved a disadvantage. The difference between patient accommodation and service areas has been expressed in the building forms. The main activities of the unit are centred on rehabilitation functions, contained in a separate block behind the wards. Owing to the long-term nature of the care, special consideration has been given to comfort and the establishment of a homely atmosphere.

VENEREAL DISEASE

1877. ROTHSTEIN, R. J., STERNBACH, G. L. and ROSEN, P. **Syphilis and pelvic inflammatory disease.** *Journal of the American College of Emergency Physicians*, Lansing, 1978, March, vol. 7, no. 3, pp. 93-95.

The emergency department of the University of Chicago Hospitals suspected that patients with diagnosed pelvic inflammatory disease (PID) might be a high risk group for syphilis. Between July and November 1976, 70 women patients with PID were screened for syphilis using three separate serologic tests. The incidence of positive serologies in the study group was significantly higher (11.4 per cent) than in a group of 100 controls (four per cent).

MATERNITY

1878. TYNE, M. D. **Assessing trends in perinatology.** *Hospital Progress*, St. Louis, 1978, April, vol. 59, no. 4, pp. 67-69, 74.

The primary concern of the perinatal/neonatal centres found in those United States hospitals with a high birth rate, is early identification of the high-risk obstetric patient. State and regional planning agencies are recommending larger obstetric units and are categorizing such units according to the services offered. As technological changes occur, the consumer demand for a more homely environment should be considered in the design of the labour and delivery suite. However, the fall in the birth rate and the rise in operating costs will mean that many units will close down. Those that remain will hopefully enable the United States to decrease still further the rates of neonatal mortality.

1879. POMERANCE, J. J. and others. **Cost of living for infants weighing 1,000 grams or less at birth.** *Pediatrics*, Evanston, Ill., 1978, June, vol. 61, no. 6, pp. 908-910.

The in-hospital cost of caring for 75 infants weighing 1,000 gm. or less at birth who were born between January 1973 and June 1975 and admitted to the Neonatal Intensive Care Unit at Cedars-Sinai Medical Center, Los Angeles, was calculated. Forty per cent of infants survived. Hospital charges were adjusted to September 1976 rates and corrected for a 94 per cent collection rate. Physicians' fees represented less than five per cent of the total bill and were not included. The average adjusted daily and total costs for the 45 infants who died were $825 and $14,236 respectively. The average adjusted daily and total costs for the 30 survivors were $450 and $40,287 respectively. The average adjusted total cost per 'normal' survivor was $88,058. The authors believe that the outcome justifies the expense, but society must be the ultimate judge.

1880. LACRONIQUE, J.-F. Les variations internationales dans la consommation de soins de maternité. **[International variations in the consumption of maternity care.]** *Hôpital à Paris*, Paris, 1978, May/June, no. 45, pp. 263-268.

In an attempt to explain variations in the consumption of hospital care between different countries and to test the hypotheses that these variations are due to economic factors or to social and cultural differences between nations, the author compiled data on the consumption of maternity care in 26 countries. He then worked out simple correlations between the various indicators (admission rate, average length of stay in hospital, level of use of facilities, birth rate, and perinatal, infantile, and maternal mortality). These showed that the variations in consumption were not accompanied by similar variations in the performance of the health system. The average length of stay—which was highest in Holland—correlated closely with economic factors. The average admission rate reflected the availability of hospital resources, but availability was not itself positively correlated with the level of the economic development of a country. These findings support the hypothesis that consumption of hospital care is not the direct expression of an objective 'need' on the part of the population but is the culmination of a large number of social and economic choices which reflect the cultural features of a nation rather than specific organizational trends.

1881. BRITISH PAEDIATRIC ASSOCIATION and ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS. LIAISON COMMITTEE. **Recommendations for the improvement of infant care during the perinatal period in the United Kingdom: a discussion group.** London, British Paediatric Association, 1978, [i], 28pp.

Various studies have shown there is a high perinatal mortality rate in England and Wales. Of the surviving infants many will carry a significant disability throughout life. Various recommendations are made for improving perinatal care at comparatively small cost. Perinatal paediatrics should be accepted as a sub-specialty with an adequate career structure and as much integration of obstetric and paediatric aspects as possible. Maternity units should be adequately staffed and equipped with special care facilities (guidelines are given). Maternal education and antenatal care are important, including early detection of 'at risk' fetuses. Mother-child contact should be ensured and breast-feeding encouraged. Recommendations are also made on: observation and examinations of new-born infants; perinatal pathology, statistics and surveys; hospital design; research; and legal and economic aspects of care. The six appendices cover:

the price of perinatal neglect and the future of perinatal care; a summary of the British Births Survey, part II; a summary of the Report of the Expert Group on Special Care for Babies; special care baby unit schedule of accommodation; certification of death; and a form for the study of perinatal mortality in Quebec.

1882. MORRISS, F. H. and others. **Determination of newborn special care bed requirements by application of queuing theory to 1975-1976 morbidity experience.** *Journal of Pediatrics*, St. Louis, 1978, April, vol. 92, no. 4, pp. 668-671.

The movement of newborn infants from the delivery room of Hermann Hospital, Houston, Tex. (a level III perinatal centre) to nursing units that provided different levels of care was studied prospectively from 1 August 1975 to 31 August 1976. The data were used in a computer modelling experiment based on sequential queuing theory to determine the relationships between numbers of available intermediate and maximum care nursery beds, the probability that a given newborn arrival could not be accommodated, and the occupancy rates for each level of care. The nursery bed requirements for the hospital were then used to estimate the number of special care beds needed by the regional health service area.

DENTISTRY

1883. ROYAL COLLEGE OF SURGEONS OF ENGLAND. FACULTY OF ANAESTHETISTS. **Report of the Working Party on Training in Dental Anaesthesia.** (Chairman: W. D. Wylie). London, Royal College of Surgeons, Faculty of Anaesthetists, 1978, 20pp.

The working party was formed to make recommendations with respect to the safety of patients under dental anaesthesia and the training which must be undergone to achieve this, and to take into account the needs of patients for general anaesthesia in the provision of dental treatment. Recommendations are presented. There are four appendices which outline: (i) core objectives on training for out-patient general anaesthesia for dental purposes, and the knowledge and understanding of the candidate at the end of his training; (ii) skills, and attitudes; (iii) specialized treatment; and (iv) premises, equipment and staff.

PSYCHIATRY

See also Abstract Nos. 1785, 1834, 1841, 1859, 1870

1884. CLARKE, J. **Security systems in high-security hospitals.** *Nursing Mirror*, Sutton, 1978, June 22, vol. 146, no. 25, pp. 23-26.

As one of the British special hospitals, Broadmoor Hospital treats mentally abnormal offenders with a high potential for physical and other forms of violence. This paper first traces the history of the hospital and outlines its present facilities. Many of the routines which formed part of the everyday duty in conventional psychiatric hospitals only 20 or less years ago are retained in special hospitals. Security, however, depends on a very significant human input of staff vigilance, dedication and endeavour. Sanctions are only used when absolutely necessary, and the emphasis is on full programmes of

occupation, education, recreation, exercise and leisure as a means of reducing frustration anxiety and tension. Nurse staffing numbers at Broadmoor are not high, but at both unit/ward level and for whole hospital functions a system of staff cover has been developed. This enables assistance to be quickly available in the event of a violent incident or other emergency. Movement of staff (and the frequent and sometimes massive movement of patients) is monitored through a VHF radio network. All visitors, official and otherwise, are escorted within the security perimeter. Patients' bed-times are fixed and a locking-up procedure and check takes place after night staff report for duty.

1885. CAULFIELD, C. **Compulsory admission of mental patients.** *Social Worker and Residential News*, London, 1978, June 22-29, vol. 6, no. 279, p. 2.

The author criticizes the practice of compulsory admission under certain sections of the Mental Health Act 1959 as a deprivation of liberty. On entering hospital, the detained patient is deprived of certain rights, including the right of unimpeded access to the courts. Appeals are heard by the Mental Health Review Tribunal, but only if the patient is admitted under Section 26 of the Act. Compulsory treatment is another controversial issue and the author believes that legislation is needed to ensure that informed consent is obtained from patients before they are submitted to psychosurgery or electro-convulsive therapy.

1886. COLLI, R. Il servizio di ospitalita' come momento terapeutico nell'ospedale psichiatrico. **[Patient care is an important aspect of the treatment within the psychiatric hospital.]** *Tecnica & Metodologia Economale*, Pisa, 1978, March/April, vol. 17, no. 2, pp. 101-109.

The most important part of this article is devoted to an account of actual or possible means of improving the life of long-stay patients in psychiatric hospitals. These patients should have some form of employment. Their diet must be well-balanced. Because of the current policy of absorbing psychiatric hospitals into general hospitals, the kitchens in existing units tend to be out-of-date, and there is a case for dismantling them and having meals brought in from another centre. The introduction of cubicles in wards would provide the patients with a modicum of privacy. The use of self-extinguishing mattresses reduces the fire risk. The problem of clothing and laundry is discussed at length: efforts are being made to mark individual laundry, to give each patient a cupboard for his clothes, and to encourage relatives to provide patients with good, well-fitting clothes. Patients who have no family are given suitable clothing by the hospital. Furniture should be kept in good repair and inventories made so that regular checks can be made.

1887. SELIG, A. L. **Evaluating a social work department in a psychiatric hospital.** *Health and Social Work*, New York, 1978, May, vol. 3, no. 2, pp. 72-87.

It has become increasingly important to determine and evaluate the activities of social work departments. This paper reports a study at the Health Sciences Centre Psychiatric Hospital, Vancouver, to determine the work load of social workers, aspects of the process of referring persons for social work services and differences between in-patients who do or do not receive social work services. Data for the study was gathered by each of the three social workers completing a brief questionnaire for each

client with whom they had a 'significant encounter' during one calendar month; of the 110 clients involved, 62 were discharged during the month. Nearly a third of all encounters were initiated by residents and medical students, a quarter by a social worker and nearly a fifth by staff psychiatrists. Generally, the social workers became involved early in the patient's stay in hospital. During the period of the study, social work intervention did not appear to affect the patients' length of stay either by increasing or reducing it. First admissions were less likely to be involved with a social worker.

1888. COMMITTEE ON MENTAL HEALTH REVIEW TRIBUNAL PROCEDURES. **The procedures of the mental health review tribunals: a discussion paper.** [London, Department of Health and Social Security], 1978, [i], 54pp.

The first chapter of this paper discusses two different approaches to the revision of the Tribunal Rules—a flexible approach with rules in only skeleton form and a more structured system to ensure consistency and to provide proper safeguards for patients' rights. Chapter two gives a detailed discussion of each of the Rules and ways in which they can be improved and the third chapter outlines possible changes in the Mental Health Act of 1959 and their effects on tribunals. Readers are assumed to have a working knowledge of the relevant provisions of the Act—but for those not familiar with the legislation an appendix discusses the role of the tribunals.

1889. KLERK, J. M. de. Psychosociale revalidatie. **[Psychosocial rehabilitation: an account of the first phase of a project initiated by the Minderpoort Rehabilitation Institute and the Office of Scientific Studies of the Community Medical Service.]** *Tijdschrift voor Sociale Geneeskunde*, Amstelveen, 1978, no. 13, pp. 425-432.

The object is to improve methods of aiding clients with psychosocial problems, as present provision under the Working Incapacity Act (WAO) seems inadequate. Clients generally suffer from uncertainty about their condition, have insufficient knowledge of legal rights, and have crises of identity and family problems which are often coupled with apathy towards treatment. The aim is social re-integration and treatment is directed at strengthening their independence, helping them handle conflicts, re-orientating them through training, and improving their physical conditions and environment. The range of therapeutic methods is briefly discussed: psychotherapy with both group sessions and individual help; introductory visits from social workers followed by regular contacts, practical help and after-care; psychomotor therapy concentrating on bodily movements; ergotherapy including a 'practicum' where clients are given their own projects to work on; physiotherapy, both individual and in groups; medical attendance; and occupational assistance, particularly important during the last stage and after-care period. These various forms of therapy are included in a 15-week programme following a two-week introduction programme and followed up by after-care. Out of 44 clients so far only 10 completed the course, the others dropped out at different stages for various reasons. The number is too small to draw general conclusions, but most clients had improved. Persuasion and speaking on the client's own level proved essential factors. A second phase of the project lasting three years was started on 1 September 1977.

1890. JACOBSEN, P. H. and HOWELL, R. J. **Psychiatric problems in emergency rooms.** *Health and Social Work*, New York, 1978, May, vol. 3, no. 2, pp. 88-107.

The diagnosis and referral of mental health problems in the emergency rooms of

four hospitals in communities of varying size were compared. The results are presented in two tables and discussed. Deficiencies in recognition and disposition existed in all four hospitals, but effectiveness of the service was related to the size of the community. The principal inadequacies of the larger hospitals were that patients receiving certain types of diagnoses tended to be excluded from referral services, and that the recognition and referral of patients' psychiatric problems appeared to be low. This suggests that many patients needing mental health treatment are not receiving such services.

1891. INTERNATIONAL UNION FOR CHILD WELFARE. **Mental retardation, the child and his surroundings: the early detection and stimulation of children in risk of mental retardation caused by socio-cultural factors; papers presented at an extraordinary session of the IUCW Advisory Group on the social problems of children and youth, Ostend, 21-25 November 1977.** (Occasional Papers of the IUCW No. 1) Geneva, IUCW, [1978], Sw. fr. 12.

The papers presented at the Extraordinary Session of the International Union for Child Welfare considered basically preventive action at the primary and secondary stages. Two lectures examined the problems of how to detect mental retardation from a psycho-analytical viewpoint and the problems of stimulating children at risk of mental retardation resulting from socio-cultural factors. Select lists of references are included after each paper. The results of the group discussions are presented together with a final summary of the session. A list of participants is included.

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